Denial Management Strategies

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Sheri provides consulting services to the healthcare industry covering both inpatient and outpatient facilities. Sheri specializes in working with healthcare revenue cycle operations, health information management/technology and compliance matters. She brings our clients a depth of knowledge from working more than 20 years in the healthcare field where she held several management positions related to medical billing, health information management and technology, medical coding, training, risk adjustment, patient business services and strategic planning.

Sheri has attained the following certifications: Certified Professional Coder (CPC) and NextGen Certified Professional (NCP). She received her Bachelor of Science in Health Policy and Administration from Pennsylvania State University and resides in Liverpool, NY.
Agenda

- The Importance of Denial Management
- Denial Prevention
- Denial Measurements
- Denial Categorization
- Denial Accountability
- Aches and Pains Medical Group (example)
- Denial Management Plan
- How we can help
The Importance of Denial Management

What is a Denial?

• **What is a Denial?** The refusal of the insurance company to pay for a service.

• Denials are communicated to healthcare entities via remittance advices. On the electronic remits (835s), the denials are sent in the form of reason codes that explain what the denial is for.

• **Often times the term denial will be synonymous with the term reason codes.**
The Importance of Denial Management

Denial Impact

• Unbelievably, studies show that only 30-50% of healthcare entities appeal denials.

• While the key is preventing denials, denials received must be worked in order to protect revenue.

• Denials can cost healthcare entities anywhere from $25-$100 a claim in rework costs.

• Unworked denials drive up write-offs and ultimately result in negative impacts to the bottom line. Cash thrown out the window!
The Importance of Denial Management

WHY do we still have denials?

• Inefficient process
• Employee turnover
• Payer product changes
• Healthcare reform
• Payer claim processing errors
• Staff bandwidth
• Consumer confusion
Denial Prevention

• Primary goal is to **Prevent** denials before they happen.
• Over 90% of denials can be prevented!
• Moving away from the “Garbage In, Garbage Out” theory.
• How can they be prevented?
  • Training
  • Tools
  • Software
  • Best practices
  • Re-training
  • Staying current on payer changes and updates
Denial Prevention

• Training:
  • What’s the **onboarding** process like for registration/front end and all revenue cycle staff?
  • Do staff receive **only system training**? (common oversight)
  • Is there **insurance training** available for staff? Regularly?
  • How is the **provider onboarding** and training process for coding?
  • Is **training continuous** in order to provide payer and industry updates?
  • **Post training audits**? To verify that new staff members are successful.

1st Letter for CPE: S
Denial Prevention

• Tools:
  • Do staff have available tools to assist in them?
    • **Insurance Reference Guides** (color coded for version control)
    • **Charge Entry guides**
    • **Coding tips** and guidelines
    • **Provider coding reference guides**
    • **Take a sticky note walk!** Look at what staff have on sticky notes on their monitors.
Denial Prevention

• Software

  • Is billing **software being maximized**?
  
  • Built in **claim edits** being utilized?
  
  • Using **eligibility verification software** to run 270/271 transactions?
  
  • **Effective claims submission** process including reviewing clearinghouse rejection reports?
  
  • **Timely submission of EDI** claims in clean, accepted claim files?
Denial Measurements

• The key to a successful denial management process is to consistently **Measure** denials.
  • Categorize all denials
  • Post all denials
  • Add denials to monthly metrics packs
  • Share reports with all areas of staff and focus on areas of responsibility
  • SLICE AND DICE!!!
Denial Measurements

Posting Denials

• Denial reporting will **ONLY** be effective if all denials (reason codes) are posted in the billing system.

• Any 835s coming into the organization should automatically be posting.

• However, for any denials coming in manually, are those being posted?

• The most accurate and effective denial metrics and reports will include all denials received, whether they come in electronically or manually (paper eobs).

• Note, as payers are not required to send 835 codes on paper eobs, it may be helpful to create some generic reason codes to post.
Denial Measurements

Denial Percentages

How to determine Denial Percentages

\[
\text{Denial percentage} = \frac{\text{Claims denied during the time period}}{\text{Claims billed out during the time period}}
\]

Example: September metrics

- $60,000 in claims denied that were posted in September, 2018. (Typically healthcare entities can run a report out of their billing system where allowed amounts or payment amounts are equal to zero.)
- $900,000 in claims were billed out in September, 2018 (Should be able to run a report out of billing systems that shows total billed during a specific timeframe)

\[
\frac{60,000}{900,000} = 7\%
\]

- Note, if the healthcare entity has mass rebills or other significant swings in claims billed out, the denominator could be switched to equal the $ value of all claims that came in that month (paid and denied).
Categorizing denials in order to simplify reporting and make it consistent across payers and operational areas.

The process of categorizing will differ depending on ability of billing software and technical ability of staff.

- Some systems allow categorization to each reason code and even at the payer specific level.
- For those systems that do not support categorization internally, the categorization can be done through database and spreadsheet tools.
- Other options include custom reports to achieve denial reporting goals.
Denial Categorization

How to categorize denials?

- Investigate how to run 835 reason code reports out of billing system.
- Identify all of the 835 codes that the healthcare entity typically sees (i.e., no need to create categories for ambulance reason codes if entity doesn’t do any ambulance billing.)
- Identify the categories that are critical to the organization.
- Assign a category to each reason code.
- Assign maintenance of this process to an individual as codes and categories change over time.
Denial Categorization

Suggested Denial Categories

- Eligibility
- No Auth/No Referral
- Timely Filing
- Coding
- Credentialing
- Billing
- Non Reportable Denials
Denial Categorization

Denial Category: Eligibility

Example:

PR33: Claim Denied, Insured has no dependent coverage

Denial Investigation:

- Was eligibility checked?
- Was insurance registered correctly?
- Run eligibility check today to verify coverage. Can it be appealed due to an insurance company update?

➢ Suggested Tools: Insurance Loading Guides, Insurance Verification Guide
Denial Categorization

Denial Category: No Auth/No Referral

Example:
**CO62:** Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Denial Investigation:
- Was the pre-auth/cert obtained?
- Is the pre-auth/pre-cert number documented appropriately?

➢ Suggested Tools: Referral/Auth Payer Guide
Denial Categorization

Denial Category: *Timely Filing*

Example:

**CO29:** The time limit for filing has expired.

**Denial Investigation:**

- How far after the DOS was the initial claim submitted?
- If there was a delay, why?
- If this was a rebill, was initial denial worked timely?
- Did the patient provide their insurance too late?

➢ **Suggested Tools:** Timely Filing Guide for payers that includes guidelines for each payer for initial submission and denial re-submission.
Denial Categorization

Denial Category: Coding

Example:

OA11: Diagnosis inconsistent with procedure.

Denial Investigation:

- Was the diagnosis that the provider selected on the claim correct (i.e., no transposed numbers, etc)?
- Was the diagnosis code correctly linked to the right procedure?

➤ Suggested Tools: Coding Libraries including tip sheets, education materials
Denial Categorization

Denial Category: **Credentialing**

Example:

**CO-B7:** This provider was not certified/eligible to be paid for this procedure/service on this date of service

**Denial Investigation:**

- Is it a new provider that wasn’t credentialed with payers yet?
- Was the credentialing issue communicated to scheduling staff?
- Is there remediation already in progress to resolve the issue?

➢ **Suggested Tools:** New Provider Credentialing Checklist
Denial Categorization

Denial Category: **Billing**

Example:

**OA18:** Duplicate claim/Service

**Denial Investigation:**

- Were there truly two different claims for the same service?
- Was it just a rebilled claim that’s already been paid?
- Were there two provider appointments on the same day, same speciality? Or provider visit and hospital admit? etc
Denial Categorization

Denial Category: Non Reportable

Example:

**PR3:** Co-Payment Amount

Denial Investigation:

- These should be for denials that **do NOT need any investigation**
- Other examples would be co-insurance, PR denials for non-covered services, etc.
Denial Categorization

Slice and Dice!

• Once the denial data (reason code categories and data) are all in a format that can be manipulated, it’s time to Slice and Dice!

• Assign this process to someone within the organization with an analysis background and skillset. (Great opportunity for the excellent biller that’s looking to learn and take on more).

  • Create pivot tables or reports that look specific trends and concerns.
  
  • **By provider** (do specific providers have higher coding denials than others, higher credentialing denials)
  
  • **By CPT codes** (are there specific codes that are creating higher denials)
  
  • **By payer** (are their specific payers that have higher denials (particularly for no auths/referrals)
  
  • **By Biller** (able to determine if particular billers have higher than others denials for timely filing)
  
  • **By Registration/Front Desk individual** that input the patient’s information (do certain staff members need more re-training, tools, or operational support)
Denial Accountability

Suggested Denial Responsibilities

- Eligibility: Operational Leadership
- No Auth/No Referral: Operational Leadership and potentially Clinical Leadership
- Timely Filing: Billing Leadership
- Coding: Coding Leadership and Physician Leadership
- Credentialing: Credentialing Leadership
- Billing: Billing Leadership
- Non Reportable Denials: N/A
Denial Accountability

Sharing Denial data (and accountability!)

- Denials are NOT only a billing department issue!
- Revenue Cycle success requires **multiple areas to have accountability**. This includes the front end/registration/intake area, check-in, check-out, billing department, coding department, providers, operational managers, etc.
- Does each area **understand the denial process** and what their goals are?
- **Is each area currently accountable** for denial metrics for their area? Is it built into their annual goals and performance evaluations?
Sharing Denial data (and accountability!)

• Suggest that denial reports are sent out monthly the specific areas showing both their area of responsibility as well as the organizational results.

• This could be combined with location/department specific leadership training sessions to kick off the process.
Driving Denial Accountability
(Example for Practice A)

• Eligibility:
  • Responsibility for eligibility denials for Practice A belongs to Operational Leadership (Office, Department, Location Managers)
  • In most cases eligibility checks are done by either a dedicated unit or front desk personnel.
  • Department A Manager receives specific denial metrics (and details) monthly.
  • The Eligibility Denial metric now becomes the responsibility of Department A Manager.
  • Each month, Billing Leadership will meet with Department A Manager to review the denials and suggest process improvement, training, or other tasks.
  • The Department A Manager also makes the Eligibility Denial metric a part of the front desk staff member’s annual goals and performance evaluation.
  • In order to drive accountability, the area that drives the denial metric should be held responsible on a regular basis for performance and improvement.
Aches and Pains Medical Group

(Aches and Pains Medical Group is a fictitious group that we’ll use to walk through the denial process)

• Aches and Pains Medical Group has a Denial Percentage of 13.1%, well over industry standard for their type of medical group.

• Past approach:
  • High level denial percentage is distributed monthly to all leadership (13.1% current average).
  • Leadership sends out e-mail communications to all staff members to drive improvement of denial percentages.
  • Billing Office sends out e-mails to front desk to remind them to check eligibility.
  • Denials are mentioned in new employee training.
  • Physician education on coding principles.
**New approach:**

- Form a **Denials Sub Team** that meets regularly with work plans, meeting minutes, updates to leadership, etc.
- **Ensure all denials (reason codes) are getting posted** monthly to ensure accurate denial reporting.
- **Categorize all denials** into standard categories used across all payers, entire organization.
- **Put all denial data and categories into reports** that can be utilized to slice and dice the information multiple ways.
- **Determine an action plan** for each significant issue identified
- **Audit staff members** with high denial rates.
- **Circle back to Denial Team each month to monitor.**
## Monthly Denial Reporting

<table>
<thead>
<tr>
<th>Month</th>
<th>Sep-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aches and Pains Medical Group</td>
<td></td>
</tr>
<tr>
<td>Dr. Smith Office</td>
<td>Dr. Williams Office</td>
</tr>
<tr>
<td>Eligibility</td>
<td>15.0%</td>
</tr>
<tr>
<td>No Auth/Referral</td>
<td>20.0%</td>
</tr>
<tr>
<td>Timely Filing</td>
<td>0.8%</td>
</tr>
<tr>
<td>Coding</td>
<td>0.5%</td>
</tr>
<tr>
<td>Credentialing</td>
<td>0.2%</td>
</tr>
<tr>
<td>Billing</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Total Denial %</strong></td>
<td><strong>7.7%</strong></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Variance</strong></td>
<td>-4.7%</td>
</tr>
<tr>
<td><strong>Overall Denial %</strong></td>
<td><strong>13.1%</strong></td>
</tr>
<tr>
<td></td>
<td>Dr. Smith Office</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
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</tr>
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<td>20.0%</td>
</tr>
<tr>
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<td>0.8%</td>
</tr>
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<td>0.5%</td>
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<td><strong>Overall Denial %</strong></td>
<td><strong>13.1%</strong></td>
</tr>
</tbody>
</table>
• By categorizing denial codes and running the reports to compare all locations, a number of things have come to light:

  • **Dr. Smith:** Slightly off overall target. Opportunities to improve on Eligibility and no auth/no referral denials.

  • **Dr. Williams Office:** Significantly off target! Issue with timely filing claims. Maybe charge entry is delayed, coding delayed, or biller have issues with this office’s claims. Also eligibility and no auth/no referral denials are high at this location.

  • **Primary Care East:** Beating target! This location likely has a process that should perhaps be considered best process and utilized at other locations.

  • **Urgent Care Main Street:** Significantly off overall target. High eligibility denials as well as high Billing denials. Possible issue with urgent care codes or places of service?
• Is that enough information to fix the problem?
• For example, the report tells us that Urgent Care Main Street needs to improve their eligibility metric.
• However, to really identify the root cause of the denials, more analysis is needed.
• Next step would be to analyze the denial reports to include the name of who registered each visit.
• This will tell us if it’s specific staff members creating the issues, perhaps a department wide issue, or maybe a number of them need additional training.
## Urgent Care Main Street Monthly Denial Reporting

<table>
<thead>
<tr>
<th>Urgent Care Main Street</th>
<th>(1) Lynn D.</th>
<th>(2) Sue S.</th>
<th>(3) Mary K.</th>
<th>(4) Diane D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>231</td>
<td>6</td>
<td>854</td>
<td>26</td>
</tr>
<tr>
<td>No Auth/Referral</td>
<td>15</td>
<td>6</td>
<td>210</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total Denial</strong></td>
<td><strong>123</strong></td>
<td><strong>12</strong></td>
<td><strong>1064</strong></td>
<td><strong>46</strong></td>
</tr>
<tr>
<td>Patients Registered</td>
<td>2831</td>
<td>162</td>
<td>3221</td>
<td>807</td>
</tr>
<tr>
<td><strong>Denial %</strong></td>
<td><strong>4%</strong></td>
<td><strong>7%</strong></td>
<td><strong>33%</strong></td>
<td><strong>6%</strong></td>
</tr>
</tbody>
</table>
What does this tell us?

• For one, it’s important to look at total number of patients that each employee registered.

• By looking at the denial reports, they show that Mary K has a significantly higher denial rate than her peers. Yes, she also registers the most patients. However, proportionately, her denial rate is still significantly higher.

• Next Steps?
Staff Denial Audits

- Suggest practices look at auditing a few of their front desk staff members each month that have higher denial rates.

- In this case, Mary K had an Eligibility Denial Rate of 33% for her visits she registered, so she will be audited.

- Instead of telling Mary she needs to improve her process, it's MUCH more effective to look at her specific denied visits.

- Pull 20-25 denials posted that month that Mary K registered.

- Review them to look for common themes or cause of denial.

- From the results of Mary’s audit, an education plan can be created. Perhaps Mary needs training on specific insurances, or it’s more software based, etc.
Aches and Pains Medical Group

Staff Denial Audits

- Mary’s Practice Manager is involved in the audit process and included in the follow up discussion.

- After identified training is completed, Mary is audited again to ensure improvement.

- Positive results on a re-audit may show that Mary is improving and benefited from the training.

- Negative results on the re-audit may show that Mary might need some additional training or other remediation.
What does the audit entail?

- An **audit template** is helpful in ensuring the audits are consistently looking at the same information. FCC can assist practices with this audit as well as the development of an audit template.

- Audits include looking at the **entire revenue cycle process** for the affected claim.
  - Was the denial/reason code posted correctly (view the eob)
  - Is the denial code appropriate from payer (sometimes payers have issues)
  - Was the patient registered correctly? Did we input all of the correct information?
  - What are the notes for that date of service/encounter?
  - Investigate the charges, coding, registration information, view image of the card, pull up eligibility information on payer website or eligibility tool, review clinical documentation, etc.
Aches and Pains Medical Group

Sound like a lot of work?

• It can feel time consuming in the beginning. However, given the re-work that it reduces in the future and the effect that lower denial rates have on the bottom line, the effort is well worth it.

• In addition, the audit provides opportunities for:
  • Rewarding effective employees for the good job they are doing
  • Identifying specific training needs for employees that need it
  • Identifying trends across the organization (ie..all employees may need a refresher on Medicare Wellness Visits, etc)
  • Provides leadership with measure information and goals to manage their staff with
• In this specific example, the audits showed that Mary K was in fact checking eligibility for the patients that she checked in. However, she was not reading the screens correctly and was overlooking when Medicaid patients had Managed Care products instead of straight Medicaid.

• In addition, it was also identified that Mary K didn’t understand how to link dependents correctly in the system.
This process highlighted a few points:

1. Sending an e-mail to Mary K to remind her to check eligibility doesn’t improve the denials. Mary was checking eligibility so she would have likely ignored reminder e-mails.

2. This audit identified that additional training time and reference tools were needed for new employees learning how to load dependents into the practice management system. All future hires will benefit from that process improvement change.

3. Mary K received the help that she needed that was specific to her in order to make her successful. That creates employee and leadership satisfaction while reducing the denial rate.
Denial Management Plan

- **Secure Executive Leadership support and buy-in.** This way the initiative is important at all levels.
- **Assess what current denial % is.** Target should be at or near industry best of <3%.
- **Create Denial Management Team** or sub team as part of a Revenue Cycle Committee. Team should include leadership and staff from billing, coding, front end, operational management, clinical leadership (i.e., physician sponsor).
- **Identify Leadership** of the Denial Management Team: **Potential co-leadership from Operational and Billing areas.**
- **Denial Team should meet monthly and should include a minimum of all leaders that have a stake** in the process. Determine how denial reports will be created, frequency, distribution list, etc.
Denial Management Plan

- Identify individuals that can train staff on denial cause and best practices.
- **Categorize Denials for reporting purposes and determine responsibility for each category** (i.e., Coding Denials are responsibility of Coding leadership, Eligibility Denials are responsibility of Operational leadership at each location, etc).
- **Analyze Denial data, Slice and Dice!**
- **Consider adding a fun aspect to the initiative** (contests, kick-off meetings with snacks, recognition for high performers).
- **Repeat!** Even if denials are at or better than industry standards, spikes in denials, staffing changes, payer updates, etc can occur at any point. Having a consistent process in place will ensure the healthcare entity is identifying and resolving issues quickly.
Denial Management Strategy

Denial Team

Train and Re-audit

Audit

Prevent Denials

Categorize Denials

Measure

Drive Accountability

Audit
How can Fust Charles Chambers help?

- Creation of an **organization specific denial management plan**.
- Provide *guidance and support for creation of Denial Teams and Revenue Cycle Committees* to oversee denials and drive organizational accountability.
- Assist with **creating and updating training programs and materials and tools**.
- Assist with **software troubleshooting, RFPs for clearinghouses and eligibility systems, implementation of software support**.
- Creation of **practice specific denial categorization reports** and regular reporting and monitoring.
- Assist with **denial investigation and best practice recommendations** to maximize operations.
- Creation of **denial audit templates and programs**.
Level 1 Free Assessment

Remote Analysis
Two weeks prior to assessment, we will review the following reports (and report availability):
- Monthly Revenue Cycle Metrics Pack
- Days in AR by Fin Class
- % of AR over 120 days
- Denial % (by payer, by reason code, location, etc)
- Charge Lag Days
- Write-off/Bad Debt reports (by reason)
- Other key Revenue Cycle Reports if available
- List of participating payers

On-site Review Meeting
A one day meeting to review the following:
- 2 hours with Rev Cycle/AR/Billing Management
- 1 hour to observe operational activity at Registration
- 1 hour to observe operational activity in Billing Office
- 1 hour to review materials (cheat sheets, training documents, etc)

Assessment
Free assessment report created and provided to organization. The report will identify strengths and focus on opportunities for Revenue Cycle improvements in addition to a Fust Charles Chambers implementation plan.

This assessment is designed to be completely hassle-free for the organization and their team.

For more information, please reach out to Sheri or Bill:

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Thank You!

Questions?

- Please reach out to Sheri Stevenson with any questions you have on this topic.

Visit our website to learn more about Fust Charles Chambers and our Healthcare Consulting Service Lines

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