CHANGE HEALTHCARE

White Paper

Rethinking Denials Management

Author

John Holyoak
Associate Vice
President, Product
Management,
Change Healthcare

Most organizations take an administrative approach to managing denials. Maybe that's why they're not collecting as much as they should.

The Denials Challenge

Few hospitals would admit to not having a denials management program, and yet as many as one in five claims for services already rendered are denied or delayed.[1]

Denials erode the provider organization's bottom line, resulting in the permanent loss of an estimated 3% of net revenue.[2] However, it's not just the cost of the denials themselves, or the revenue lost–3% of the bottom line is significant no matter how it is sliced–it costs an average of $25 to rework an individual claim.[3] The opportunity cost of resources that could be focused on other activities is huge, as is the cost in terms of days in A/R from the revenue cycle perspective.

That's the bad news. The good news (if you can call it that) is that about two-thirds of denials are recoverable, and almost all (90%) are preventable.[4] The problem is that many provider organizations continue to view denials as a back-of-the-house, patient handling problem, although studies reveal that 30-40% of denials are attributed to registration errors.[5] Another problem is that denials are often addressed as administrative issues when there are often clinical factors involved.

It turns out that most denial management programs have several flaws that, if corrected, can close the gap on those 90% of preventable denials. A common flaw is not focusing enough attention on the front-end of the revenue cycle; another is not addressing denials from a holistic, organization-wide approach that includes the intersection of financial and clinical factors.

To understand how that approach can be implemented, let's look at some of the most

[1] PNC Financial Services Group, Automated Billing/Payment Process Can Reduce U.S. Health Care Costs without Sacrificing Patient Care, November 2007

[2] Driving the Denials Management Initiative, a Renewed Focus, The Advisory Board Company, Washington, D.C., web conference, July 2009

[3] http://www.hfma.org/Content.aspx?id=32086

[4] "An ounce of prevention pays off: 90% of denials are preventable." The Advisory Board Company, Dec. 11, 2014

[5] HBI Academy Research, Registration Errors Significantly Impact Reimbursements

prevalent denial causes and then explore avenues for action to stem them.

Common Causes

Consider the top reasons for denials and how often they occur:

Denial Reason	Freqency
Registration/Eligibility	28.0%
Duplicate Claim/Service	19.2%
Service not Covered	15.0%
Missing or Invalid Claim Data	11.7%
Medical Documentation Requested	6.6%
Authorization/Pre-Certification	5.8%
Medical Necessity	5.4%
Medical Coding	4.3%
Untimely Filing	3.1%
Coordination of Benefits	1.1%

Source: Change Healthcare network data

Much of the information needed to get a claim to the right payer with the right core data about the patient is gathered prior to service. So the 30 to 40% of denials seen downstream are the result of registration and pre-service related challenges—issues that can and should be prevented.

Pre-authorization is another huge source of denials and work effort. Nursing staff spend over 13 hours per physician per week on prior authorization–far more than any other administrative interaction.[6] And 78% of physicians in an AMA study said eliminating the hassle of pre-authorization is "very important."[7] Pre-authorization and medical necessity related denials account for more than 11% of all denials, and span both the revenue cycle and clinical realms. This is just one area where the alignment of revenue cycle and clinical teams can help with denials management.

Analysis Enables Strategic Action

In the not-so-distant past, revenue cycle work (and, hence, staff) was predominantly clerical in nature—whether it was coding claims, working claim edits, or doing pre-registration and registration activities. Today, with new systems and technologies to manage those clerical functions, a larger portion of revenue cycle staff have titles like analysts and data scientists. Any

good denial prevention/resolution process should be grounded in core analytics—using tools to understand available data to determine where the problems lie. But even with good data we need organizational support. Data should not be used as a weapon as you enter into a dialogue with clinicians or patient access areas. It should be used as informative and interchanging.

Considering the spectrum of denial reasons, it's apparent that this is an organization-wide problem that must be managed by multiple disciplines. So identifying and addressing the root causes of denials has a larger financial benefit than appealing and overturning denials.

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Managing denials should begin with using available data to analyze where errors and slowdowns occur, prioritizing those causes, and then addressing them.

Root causes can originate anywhere—from patient access and registration, insufficient documentation, and coding/billing errors to payer behavior and utilization/case management. Once the root cause is identified, it must be analyzed to determine which has the greatest impact: whether a certain physician, service line, or payer, a certain type of code, or a process in need of redesign in both the clinical and revenue cycle areas. Armed with an analysis, you can begin to both prevent and manage denials in a more strategic, deliberate manner.

[6] HealthAffairs, What Does It Cost Physician Practices To Interact With Health Insurance Plans? 2009
[7] AMA Survey of Physicians on Preauthorization Requirements, May 2010

Revenue Cycle Prevention Strategies– Registration/Eligibility

As reflected in the denial data presented above, registration/eligibility errors account for the largest percentage of denials, and so they represent the best chance to improve overall revenue cycle performance. Eligibility denials often occur when a payer is no longer responsible for coverage. Not everyone's eligibility changes "on a dime," but some parts can. How much of the deductible has been met? A remaining deductible of $5,000 could drop precipitously between the time eligibility is first checked and when the bill is posted. Other coverages can be retroactive, which would also impact eligibility.

Root-cause analysis may reveal that the patient access staff is not performing thorough eligibility verification. The solution would involve confirming eligibility at scheduling, then three days before elective service, on the date of service, and once more before submitting the claim. For emergency patients, eligibility should be checked at the point of service, and patients who undergo unscheduled procedures should be contacted

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within 24 hours. The tools are there to enable these multi-point eligibility checks. The data is available in real time, and should be used that way.

It can't be stressed often enough that revenue cycle success begins at registration. Registration errors vary widely, but can be as simple as a missing member ID prefix. The application of business rules and tools to examine registration data can help improve accuracy, completeness, and consistency. Errors can then be fixed in the workflow, in real time, to help prevent downstream denials.

Pre-Authorization

Denials caused by pre-authorization are usually due to failure to secure an authorization in advance, or a clinically-driven change in the procedure. Authorization starts with procedure-specific policies crafted and managed at the payer, plan, employer, and group levels. To grasp the scope of the policy problem, consider the number of different payers and plans encountered daily. An examination of 1,300 policy documents across multiple payers looked for commonality across procedures (what requires an authorization and what doesn't). It revealed only about 8% commonality across payers and plans.[8] The decentralization of the pre-authorization process in hospitals and health systems is another issue, but ultimately it is the physician who is responsible for securing an authorization prior to service.

The solution is to shift from a reactive approach to a proactive solution that provides many more points of integration and a seamless flow of information from provider to payer and back to provider. Plus, by providing clinical guidance and evidence-based support throughout the process, instead of operating in a reactionary mode, providers can improve efficiency and reserve expert resources to addressing those complex cases that require exceptions. Best practices for minimizing pre-authorization and medical necessity denials include:

- **Define roles and ownership**—Designate a team to govern the pre-authorization process and ensure a reliable and stable approach.

- **Automate screening and verification**— Automate pre-authorization screening and verification–and have it embedded in workflow–to know what requires a pre-authorization, and to verify that it is in place.

- **Automate payer policy maintenance**— Automate the location, capture and maintenance of payer authorization policies to increase accuracy and reduce

[8] Change Healthcare review of payers and plans

administrative burden.

- **Automate authorization acquisition**—Obtain the authorization with automation, including evidence-based support.

- **Get a handle on medical necessity**—Medical necessity is foundational for a broader set of process opportunities that can reduce denials and help improve care quality. As such, the case management system must be examined to identify gaps that cause denials.

Aligning Revenue Cycle and Clinical

Revenue cycle staff needs to share data and provide insight into where the opportunities are to prevent errors, streamline processes, and determine where to focus denial prevention and management efforts.

While leadership might have an understanding of the resources wasted and revenue lost, and the case manager might have a strategy to improve performance, the clinical staff rarely if ever sees a report on denials. They don't know length-of-stay or denial rates and they're not being asked for input on how they can help improve processes. Ensuring that operational reports from finance and revenue cycle are being circulated and reviewed can go a long way toward bridging this gap. Ultimately, data should be the driver of a denials management program. Teams need access to reports to build action plans for improvement. If you have the data, and teams are developing action plans and looking for improvement opportunities, they will find ways to reduce denials, length-of-stay and cost, and help improve quality.

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