Best Practices for Denials Prevention and Management

Save to myBoK

The direct fiscal impact of ever-increasing claim denials spans the healthcare continuum, including large health systems, independent hospitals, physician group practices, solo providers, and post-acute care facilities. A 2017 analysis of 850 hospitals' payment transactions revealed that initial denial rates among five national payers varied from 7.5 percent to 11.1 percent of net patient service revenue (NPSR)—meaning $1 of every $10 of revenue is at risk for nonpayment.[1] Nearly $3.5 trillion was spent on healthcare in the US in 2017, and that spending is projected to grow to $5.7 trillion by 2026.[2] Extrapolation of this data clearly illustrates the significant financial impact of claim denials on US healthcare providers.

A best practice for mitigating financial risk is a proactive and preventative—not reactive—approach to denials management using claims data for denials prevention. This approach will enhance revenue by minimizing the number of denials, reducing the amount of uncollected revenue, and lowering the associated staff costs required for the appeals process.

The path to long-term successful denials prevention begins with a clear vision that is articulated in a formal denials prevention plan that includes stakeholders from across the healthcare continuum.

Role of Claims Data and Analytics in Denials Prevention

Claims data provides a comprehensive snapshot of a patient's encounter. This data is valuable in identifying accounts for further review that may be at risk for denials based on current patterns.

Key elements of claims data include:

- Patient demographics
- Diagnoses
- Procedures
- Modifiers appended to outpatient procedure codes
- Date(s) of service
- Service provider/national provider identifier (NPI)
- Revenue codes
- Occurrence codes
- Status codes
- Plan and payer information
- Charges and reimbursement for episode of care

Claims data is rich with information that can be measured at the individual level and can aid in treatment decisions, as well as generalized data that can be extrapolated and applied to a broader population. To ensure all these quantitative and qualitative elements are measurable, the data must be accurate and clean from the source.

Data analytics can be employed to proactively minimize claim denials and improve coding accuracy, thereby contributing to an overall denial prevention strategy. Many healthcare organizations use a case-by-case auditing approach once a denial is received. However, a more global strategy is the analysis of an organization's claims database which allows for the identification of denial-prone codes as well as potential denial trends. This allows an organization to proactively identify and correct potential sources of coding-related denials on a much broader scale and to craft education surrounding the findings to prevent future errors.

The Office of Inspector General (OIG) Monthly Updates Work Plan is a valuable industry resource that identifies projects such as OIG audits and evaluations that are underway or planned. There is no longer an annual work plan, but instead individual issues on a monthly basis. Other industry resources include the Recovery Audit Contractors' (RACs) focus areas, as well as the American Hospital Association's *Coding Clinic*, the American Medical Association's *CPT Assistant*, the National

Correct Coding Initiative Edits (NCCI), and various trade journals, newsletters, and blogs that discuss coding issues. Internal resources that can be used to develop claims database analytics include internal and external coding audit results, root causes of previous claim denials, and the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER is a comparative data report that summarizes a hospital's Medicare claims data statistics for areas prone to abuse/improper Medicare payments.

Based on the volume of potential coding issues to be analyzed, an organization should prioritize issues that represent common diagnoses and procedures, high-dollar cases, and issues that relate to quality and safety measures and value-based purchasing.

Regulatory Resources for Outpatient Coding and Auditing of Facility and Professional Fees

- CMS Claims Processing Manual: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
- Medicare Physician Fee Schedule (MPFS): www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/
- National Correct Coding Initiative (NCCI) Edit Tables for Procedure to Procedure (PTP): www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

  - Medically Unlikely (MUE): www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
  - Add-on Code Edits: www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html

- NCCI Policy Manual: www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- NCCI General Correspondence Language and Section-Specific Examples (for NCCI Procedure to Procedure (PTP) Edits and Medically Unlikely Edits (MUE)): www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/2016-NCCI-Correspondence-Manual.pdf
- National and Local Coverage Determinations (NCD/LCDs): www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx
- Appendix A, available in the online version of this Practice Brief in AHIMA's HIM Body of Knowledge at http://bok.ahima.org, offers additional guidance on the above resources.

Life Cycle of Claims

The life cycle of a claim begins from the moment a patient is seen by a provider and ends when all outstanding payments from clean claims are received. Administrative, clinical, and health information management (HIM) and coding staff must follow specific processes to help ensure correct and timely reimbursement. Omission of any step in the process may cause the claim to be ineligible for payment, resulting in a claim denial. Patient demographics collected by registration and/or patient admitting representatives is key and critical to the coding process.

Healthcare organizations should keep the following basic steps in mind for effective results-oriented claim processing:

- Efficient scheduling and pre-registration data collection
- Health record documentation
- Charge capture and coding
- Claim submission
- Claim follow-up
- Timely claim payment posting
- Timely denials, appeals, and collections processing

Provider documentation is the basis of coding diagnoses and procedures for an encounter. The accurate collection and appending of coded data to a claim form initiates the reimbursement process. Once internal billing edits are resolved, a claim is

generated and submitted to the payer. The claim is then tracked for payment. Should the payer issue a denial, the appropriate entity within an organization is responsible for the correction. There is a shared responsibility for review of claims denials among HIM, clinical documentation improvement (CDI), patient accounts, and the department originating the charge. The HIM department may be the preferred entity to lead denials management by validating that provider documentation supports the correct code assignment.

Appeals Process

Organizations that view coding denials as learning opportunities strategically empower themselves to strengthen their ability to successfully appeal and ultimately reduce future denials through an improved clean claim rate. Although a trend of rogue denials is on the rise, methods exist that allow providers to take legitimate denials and use analytics to craft effective defense strategies. The best defense against denials is a singular organizational vision of revenue integrity wherein all stakeholders collaborate to achieve this goal. After determining a claim denial is legitimate, the specific issue(s) that prompted the denial must be carefully examined from all angles:

- **Step 1 – Clinical Documentation Analysis:** Perform a thorough review to ensure that consistent and complete clinical documentation was present in the health record at the time of coding. If documentation gaps or inconsistencies are identified, a collaborative effort between CDI and HIM should be undertaken to identify problematic documentation trends in order to create better documentation strategies. Robust dialogue among clinicians, CDI staff, and HIM staff can help improve disconnects between medical language and coding language—thereby reducing impediments to correct coding.
- **Step 2 – Coding Analysis:** Coding denials offer stellar opportunities to identify knowledge gaps in an organization's coding staff. Focused internal audits, based on identified denial patterns, are an important and proactive component of denials prevention. Audit results not only illuminate erroneous coding patterns but also provide an understanding of the logic that underlies them. It is important to remember that coding professionals are faced with time constraints due to the complex and ever-expanding nature of ICD-10 and CPT coding coupled with productivity expectations. Coding professional time constraints may result in missed query opportunities, imprecise coding, lack of attention to coding guidelines and conventions, and incorrectly assigned present on admission indicators. The method of efficient coding, without sacrificing quality, should be taught to all coding professionals whose efforts will, in turn, positively impact denial rates.
- **Step 3 – Create a Long-Term Denials Prevention Plan:** Each new round of coding denials offers the opportunity to perform clinical documentation integrity and coding quality analyses. Providing continuous education to correct the knowledge deficits for the CDI and coding staff will result in greater accuracy in coding and claims submission and a reduction in appeals for the long-term.

Regulatory Considerations

The impact of regulatory oversight in claims processing cannot be overemphasized. Lack of competency in this area is a consistent reason for claims denials and delays of payment. This problem extends to coders, auditors, and coding managers. There are thousands of pages of regulatory guidance that may lead to quick resolution of edits and denials, but staff members must be aware of how to access these resources and then how to correctly apply the guidance. For many coding professionals, the edit resolution process is more a matter of guesswork. This is not due to a coding professional's lack of consideration about these issues; rather, it is more a matter of a failure to understand what resources may be used to assist them. This can be easily corrected by sharing with staff members the valuable resources created by the Centers for Medicare and Medicaid Services (CMS) to guide edit resolution actions.

For outpatient coding and auditing of facility and professional fees, the regulatory resources in the sidebar on page 37 are available to assist in ensuring correct coding. These resources, and the guidance found within, may potentially affect codes on every claim and many times follow and support coding directives as found in the *CPT Manual*. CMS does have some directives that are not found in CPT, and vice versa. When coding for claims for Medicare and Medicare Advantage Plans, follow the regulatory guidance. Individual commercial payers may have their own directives in this regard.

Benchmarking Overview

Benchmarking is the process of comparing and contrasting an individual facility's or organization's business process and performance metrics with industry best practices.

An organization may have multiple data sources against which analyses can be performed to help improve coding accuracy. These data sources include registries and individual departmental databases. The types of analyses can be very specific to organizational needs.

For example, a hospital with a pattern of failure to code and report tracheostomies when performed can use the respiratory therapy department's database to identify all tracheostomy cases for analysis. Similarly, an orthopedic department's joint replacement database could be used to identify all bilateral joint replacement and revision cases for review.

Data analytics techniques can be a powerful tool when developing and analyzing benchmark data. Consideration must be given to the following factors:

- Timeframe in which data was compiled
- Appropriateness of benchmark providers or organizations selected
- Specific measures used (e.g., procedure code, DRG, charges, costs, LOS) for comparison

Benchmarking Data

Although there are diverse methods of benchmarking an organization's coding data, this data analysis trending model provides a simple method for facilities to compare their MS-DRG patterns to publicly available CMS MS-DRG benchmarks. The resulting quantitative data provides facilities with a customized scorecard that can be used to craft targeted coding and CDI reviews based on deviations in CC and MCC reporting from the national mean. Certain payers utilize this method to identify specific MS-DRGs per facility that vary from the national norm. How this information is used varies depending on the payer and extent of deviation, but generally will bring increased payer scrutiny upon the provider. This data analysis trending model is a powerful tool that can be used by HIM and CDI alike. The model aligns with the current trajectory of US healthcare and supports quality measures, data accuracy, and revenue integrity.

Considerations to take into account include:

- Does my facility's CC/MCC capture rate for a given principal diagnosis align with the CMS mean?
- Is my facility potentially under-reporting or over-reporting CCs or MCCs for a given MS-DRG?
- What is the value of conducting an internal review of CC/MCC capture rates based on CMS MS-DRG benchmarks?
- How can I use this data analysis model to positively impact my facility's data quality and overall financial health?

To find the CMS benchmark data, follow these steps:

- Navigate to www.cms.gov
- Search for Fiscal Year Final Rule Tables
- Table 5: List of Final MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
- Tables 7A and 7B contain the number of discharges, and selected percentile lengths of stay

The formula for utilizing Tables 7A and 7B is as follows:

- Add the total number of discharges per MS-DRG set
- Divide the MS-DRG volume by the MS-DRG set total volume
- The results equal the percent of MS-DRG set total volume per MS-DRG
- Use the same formula with your facility's data
- Subtract percentage of MedPAR MS-DRG from percentage of facility MS-DRG

Example of MS-DRG Benchmarking

For illustrative purposes, consider the heart failure MS-DRG set (DRGs 291, 292, 293). According to the Centers for Disease Control and Prevention, the national estimated cost to treat heart failure annually is $31 billion. Fiscal Year (FY) 2018 ICD-10-CM code changes included numerous new and revised heart failure codes that allow more granular categorization and capture

of heart failure data. It can take time for documentation and coder knowledge to catch up with the ever-expanding ICD-10-CM code set. As such, it is wise to benchmark your facility's DRG reporting against the national benchmarks with data found in Tables 7A and 7B. Table 1 below illustrates a facility wherein DRG 291 exceeds the national benchmark and DRGs 292 and 293 fall below the national benchmarks. Focused audits of this MS-DRG set could potentially reveal both under- and over-reporting of heart failure data and their accompanying MCCs and/or CCs.

Table 1: Example of Benchmarking MS-DRG Hospital Data with CMS National Data

DRG	DRG Title	Hospital Data Example	Variance	Risk
291	Heart Failure & Shock W MCC	10.01%	Over National Benchmark	Denial Risk
292	Heart Failure & Shock W CC	6.37%	Under National Benchmark	
293	Heart Failure & Shock W/O CC/MCC	3.64%	Under National Benchmark	

While it is possible to benchmark code edits, delays of payment, and/or denials without having full regulatory competency, there is greater understanding of the issues involved if the data is more than just a number. An understanding of the deeper issues underlying the reasons for edits and denials is essential to a successful revenue cycle. For example, the grid in Table 1 contains insightful data into potential over-reporting and under-reporting of MCCs and CCs for a given DRG family. A next step would be to perform quality audits surrounding documentation and coding for cases that group to DRG 291 to determine the legitimacy of the MCC capture rate. The same logic could be applied to cases that group to DRGs 292 and 293 to determine if missed revenue opportunities exist. The audit findings can be used to identify erroneous documentation and coding trends which can then translate into best practice education for all stakeholders. All HIM staff members performing data analytics would benefit from expanding their knowledge and competency in this area.

Denials Prevention and Management Programs Offer Value

Programs to prevent and manage denials not only bring tangible fiscal value to organizations, but also enhance the skillsets of the HIM professionals who create and manage them. The financial value of denials prevention and management programs varies directly with the amount of strategic global thinking, time, and effort invested in the process. The implementation of a proactive denials management strategy often requires an additional investment of time on the front end, while continuing to process retrospective cases and meet appeal deadlines. The result, however, often yields a significant reduction in initial denials through analysis of coding targets, concurrent audits, and education of coding staff. Once a proactive denials management program is in place, a culture of continuous quality improvement takes root, involving stakeholders across the healthcare continuum.

HIM professionals are uniquely positioned to take leadership roles in their healthcare organization to successfully navigate the complex issue of payer denials, as thorough knowledge of coding and clinical documentation integrity is essential to the process. A positive impact on an organization's bottom line from a reduction in denials will help ensure a place at the table for HIM professionals with other revenue integrity stakeholders. Most importantly, a reduction in denial rates directly translates into more available revenue for patient care.

Notes

1. Taylor, Mark. "Increasing Payer Denials, Uninsured Challenge Hospital RCM." HFMA. December 7, 2017. www.hfma.org/Content.aspx?id=57245.
2. Advisory Board. "How much did the US spend on health care last year? $3.5T, according to CMS." February 15, 2018. www.advisory.com/daily-briefing/2018/02/15/health-care-spending.

Prepared By

Sue Bowman
Angela Campbell
Lisa Crow
Maggie Foley
Daniel Land
Famey Lockwood
Faith McNicholas
Christine Poleon
Donna Rugg
Lynn Thornton

Read More
Appendix Available Online

http://bok.ahima.org

The online version of this Practice Brief, available in AHIMA's HIM Body of Knowledge, includes the following additional content:

- Appendix A: CMS Claims Processing Manuals

Article citation:
AHIMA. "Best Practices for Denials Prevention and Management." *Journal of AHIMA* 90, no. 3 (March 2019): 36–39.

Driving the Power of Knowledge