Bringing Down Denials: Successfully Managing Denials in Medical Practices

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Resolving past denials and preventing future ones takes work. But making denials management a part of the practice's daily work pays off on the bottom line.

When accounts receivables are not what they used to be, the reasons vary from practice to practice. However, nearly every practice can improve its bottom line by managing denials.

Although rates vary from state to state, payer to payer, site-of-service to site-of-service, and from service to service, denials range from 10 percent to more than 50 percent of claims filed. The payment for denied claims processed in a well thought-out plan can be well over 50 percent and in some situations closer to 75 percent.

Lowering denials-and keeping them low-requires a process that becomes a part of the practice's daily business. Denials management falls into three broad steps: logging and responding to denials, understanding root causes, and creating an action plan for preventing future denials. The ultimate goal of every denials management program should be prevention.

Real Costs, Shared Responsibility

Payers deny payment for a multitude of reasons, which they indicate through denial reason codes. A denial by definition is a bill the payer has accepted but will not pay for a specific, stated reason; for example, the bill has been sent to the wrong primary or secondary payer, the patient lacks current coverage, coding is deemed inaccurate, or proof of medical necessity is missing.[1]

Every medical practice's goal should be a clean claim on the first submission. Appealing a denied claim requires money as well as time. The average cost to process a first appeal ranges from $20 to $25 per claim. The cost rises if a claim requires additional appeals. Profits diminish quickly when claims are not clean on first submission.

There are even situations when an appeal would cost the practice more money than it could recoup. A $25 appeal on an $11 denial loses the practice $14.

Whether they are appealed or not, however, all denials should be actively resolved. Simply "working or correcting a denied claim" is not the same as resolving it. When the clinical or administrative process that produced the denial remains unchanged-such as incorrectly linking a CPT and ICD-9-CM code or billing a service that is considered bundled-the denial will be perpetually reproduced. The practices that identify and correct the sources of their denials have better bottom lines.

Every staff member is part of the practice's billing process-from registration and access staff to physicians and clinical support staff, through to patient check-out, coding, and billing staff. It can be helpful for all new staff members to spend time in the billing area during their orientation. The appreciation and knowledge they gain there will benefit the practice's billing process. Similarly, an increased sense of ownership throughout the entire process flow enhances the practice's compliance.

The number of a practice's denied claims directly relates to its level of automation and the services it performs. Practice management, billing, and electronic health record systems assist in claims processing. Clearinghouses, encoders, and medical necessity systems enhance clean claims processing. Without such systems, it is extremely difficult, if not impossible, to obtain a comprehensive knowledge of bundled services, national and local coverage determinations, and payer restrictions.

Receiving the Denial

A common roadblock in denials management begins with the response to this question: What to do when a denied claim is received? One typical action is to set the denial aside and work another step of the billing process-something more familiar, namely processing that day's claims.

Unresolved denials quickly accumulate to a proportion that appears unmanageable. As time passes, the likelihood of addressing them diminishes, as does the opportunity to appeal them.

Practices benefit from a simple process for receiving denials. If the practice completes its billing internally, monitoring denials is easier. If billing is completed by an outsourced company, then the practice must rely upon someone else to act on its behalf. Some practices may not even know their denial rates by physician or provider.

A denial is easy to identify because $0 dollars are reimbursed. Claims denied as duplicate claims should be investigated. The first step is to verify the number of times that the service was performed. Some services are actually performed more than once a day. For example a patient may receive laboratory services in the office during a scheduled morning appointment, such as glucose testing, and return in the afternoon for the test to be repeated. Without the appropriate modifier attached to the claim, the payer may perceive the laboratory services as duplicative and produce a denial.

More difficult to identify are correct reimbursements based upon currently contracted reimbursement rates with a particular payer. Payers are not always correct with the reimbursement they issue. Without the use of software such as managed care modules to the practice management or billing systems, this is difficult for the practice to identify.

Common Reasons for Denied Claims

- Medical necessity (either ICD-9-CM code or frequency of service)
- Noncovered service
- Bundled service
- Mislinked diagnosis and procedure codes
- CPT code submitted to Medicare rather than required G code
- Payer error in software, such as incorrect age mapping to CPT code
- Other insurance is primary
- Procedure not paid separately
- Incomplete information
- Coverage terminated
- Provider not eligible for service
- Service under global period

Understanding the Denial

Essential to accurately processing a denial is understanding why the claim was denied. Inaccurate appeals cost the practice. Common issues in denied claims include medical necessity, bundled services, and coding errors (see sidebar above).

The key to understanding why a claim was denied resides in the denial reason codes. It is critical that the practice obtain a thorough understanding of each denial reason code in order to accurately process appeals. Acknowledging what the payer needs to approve the claim-such as operative reports, consultation orders, or history report-will also assist with the payment of a denied claim.

Preventing Denials

Quality checks and good processes throughout the practice contribute to clean claims that are paid on first submission. It begins with the staff member who first speaks with the patient and continues through to staff who monitor and address each denial the practice receives.

Collecting Accurate Patient Information

A medical practice's first contact with a patient is often over the telephone. Whether the patient speaks with a member of the clinical or administrative staff, accurate collection of demographic data, including current insurance information, is the first step in preventing claims denials.

Verifying a patient's insurance coverage prior to any professional service is a best practice, but using technology to capture accurate insurance information is a "must" in a strong prevention program (e.g., scanning or copying the patient's current insurance card). Staff should verify coverage at each patient visit.

One false assumption that can lead to denial is that insurance coverage is valid for one calendar year. Many employees do have coverage for 12-month periods, but coverage may not run January 1 to December 31. In addition, staff should consider that in the current economic climate, when jobs (and insurance coverage) are being eliminated, an insurance card that appears valid may be obsolete.

All patient data also must be accurate. Claims are often denied due to basic human oversight. The practice may know a patient as Billy, for example, yet his insurance card, and thus his coverage, lists him as William. Similar scenarios occur with simple keying errors such as transposed numbers in any demographic field.

Eligibility issues are not limited to patient demographic errors. Coverage denials may be based upon the patient's date of surgery. Prior eligibility must be obtained from the payer when surgery is involved in a patient's care.

This is not as simple as asking if a payer covers a given surgery. It is necessary for the practice to ask the payer if a specific patient is eligible for a specific surgery (specifying the CPT code) performed on a specific date by a specific surgeon.

It is important to confirm that the physician who will perform the surgery is credentialed and contracted with the payer. A procedure may be covered by one physician in the practice while not covered for another who may not have completed the credentialing process. Many payers offer eligibility verification online, and practice staff may quickly verify coverage, even for office visits. Any time the practice can identify noncoverage issues prior to the service being performed, it will save time, energy, and money for the practice.

Proper Training and Up-to-Date Resources

Once a patient's demographic and insurance information is collected, then the practice's most important business form comes into play.

Some practices call it the charge slip, while others call it the superbill, encounter form, fee ticket, visit slip, or patient slip, to name a few. A well-designed charge capture process, whether in electronic or hard copy format, reduces the opportunity for denials.

Obviously, CPT, HCPCS, and ICD-9-CM codes must be current, and all services performed at the practice and their codes should be included. If the practice uses an outdated charge slip, it will receive denials for submission of incorrect codes with all payers for every claim that assigns these codes.

Incorrect linking of a service or procedure (CPT or HCPCS code) to a diagnosis (ICD-9-CM code) creates another opportunity for denial. For example, the practice sees a female patient for a preventive visit (99381–99397), yet the provider identified and evaluated irregular bleeding as a significant problem. An endometrial biopsy was performed during the visit. Correctly linking the ICD-9-CM "well" V code to the preventive visit code and the ICD-9-CM "sick" code to the endometrial biopsy procedure code will ensure proper payment for these services. In this scenario, modifier -25 attached to the "sick" office visit (99201–99215) code is necessary for proper reimbursement. Linking the ICD-9-CM "well" V code to the endometrial biopsy procedure code would result in a denial.

Of all the mechanisms available to reduce and prevent denials, appropriate training and necessary resources are one of the top ways-if not the top way-to reduce denials. Whether denials are processed manually or with sophisticated computer systems, if staff do not know what a denial means, cannot analyze a report, or cannot use the software to its potential, then the practice is

sure to have a major denials problem. Staff training may take many forms, such as on-site presentations, audioconferences, and webinars, but it should include all aspects of accurate charge capture and denials management.

Keeping coding resources up-to-date helps keep denials down. Coding books and software should be for the current year, and the staff should have access to the latest information on how to utilize proper coding principles, including modifier use. All coding changes should be updated in electronic or manual processes prior to the effective dates.

In addition to these periodic changes, practices must keep current on National Correct Coding Initiative edits, national coverage determinations, and local coverage determinations. These resources are available online through the Centers for Medicare and Medicaid Services at www.cms.hhs.gov. These bundling and coverage guidelines offer a wealth of information when resolving denied claims. Additionally, each payer may have coverage guidelines, especially for services not included in the NCCI edits or NCD and LCD guidelines.

Denial Tracking Form

Payer_____

Physician_____

	Patient Name	Account Number	Date of Service	CPT Code	ICD-9-CM Code	Date Denial Issued	Denial Code	Charges on Claim	Denied Dollar Amount	Date Requested	Action Taken	Recovered Amount
1												
2												
3												
4												
5												
6												
7												
8												
9												

Denial Database Summary

Month_____

Payer	Total Open Accounts	New Accounts	Total Dollars Pending	% of Dollars at Risk	Closed Accounts Won	Dollars Recovered	Closed Accounts Lost	Dollars Lost
1								
2								
3								
4								
5								
6								
Total								

Determining Top Denials

Practices may address denials at this point in the process by first identifying their top 10 payers through a payer mix report from the practice management or billing system. Next they should identify the procedure codes that are most frequently involved in denied claims.

Then, comparing the top payers with the most frequently denied procedure codes, staff can review the payer Web sites, newsletters, and administrative manuals for coverage guidelines. Some of these guidelines will list acceptable frequencies of service along with a listing of diagnosis codes that support the medical necessity.

Payer policy and procedures for appeals also may be located in manuals, newsletters, and online. The practice has one chance at the first step to appeal each denied claim. Understanding the correct appeal process for each payer is essential to overturning a denied claim.

The appeal may include, but not be limited to, clinical documentation of the service performed, the physician's clinical necessity for providing the service, and additional supporting documentation such as Medicare coverage guidelines, AMA's CPT coding book references, scientific research, and specialty medical society supporting statements or published research. Copying patients on this correspondence lets them know the practice is working on their behalf.

A Denials Action Plan

Understanding and properly appealing denied claims is only part of the denials process. Practices must have a formal method for monitoring denials-often called denials management. At the heart of denials management is a denials action plan.

The plan includes a denials database that consists of the identification and explanation of all denial reason codes; electronic file receipts; deadline dates; and profiles based on payer, reason, diagnosis, procedure or service (CPT or HCPCS code), and physician or provider.

Key to identifying areas of focus is tracking and trending denial data. Computerized tracking programs or spreadsheets assist with denials management. Samples of two hard-copy tracking tools may be found on page 35.

The practice may choose to monitor specific areas or departments, or it may break down the analysis by other variables such as office location, physician, specialty, or specific procedure. The data will reveal patterns or trends in denials. For example, the practice may be experiencing consistent denials for one physician. Identifying the denial issues, investigating the potential solution, communicating the findings with the physician and appropriate staff, and monitoring the results are all steps in finding a resolution. Resulting good news should be noted and shared, too, such as declines in specific denials or dollars recovered.

A denial work team should include representation from each specialty or area of the practice. The team is responsible for establishing a denial benchmark, such as 1.5 percent of gross revenue; tracking and monitoring denial statistics and trend improvements; itemizing each denial reason code and explaining response or project status, which will likely include health record documentation review; identifying and resolving unique payer issues associated with denials; documenting information systems issues; identifying the action(s) necessary to lessen or eliminate denials; and developing an educational plan.

Part of the denial work team's efforts will include key reporting and trending of denied accounts. For example, the team may identify the top 100 CPT and HCPCS codes the practice submitted during a calendar year, then sort by the percentage denied. In multispecialty practices, this analysis would be completed for each specialty, then for each physician or provider. Primary care practices will sort by physician or provider. Each of these reports may be sorted by payer as well.

Codes denied 100 percent of the time, such as 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory), should receive their own category. The team's next step will be to trend by code or physician to resolve the denial issues.

Trending denials also helps the practice determine the top denials by payer. This information may be coordinated with the denial resolution for each type of denial. The team then documents, publishes, and distributes the details of denial trending and resolution by payer, including sample appeal letters, to practice staff. This information will speed the appeal process for the staff working the denials.

Included in the denials action plan are benchmarks for the practice. Benchmarks are set by the answers to the following questions:

- What percentage of the claims are rejected? This should be less than 5 percent of all electronic claims submitted.
- What percentage of claims are denied by payer? This rate should be a single digit.
- What is the dollar amount of the denied claims? This varies greatly based upon specialty.
- What are the top denial reasons, and are there consistencies by physician or provider or by payer? Once analyzed, the practice may discover that many of the denials are a result of one issue or are produced by one provider.

- What is the appeal rate by payer? This should be dissected by CPT and HCPCS code to fully understand the denials and determine a resolution.
- What is the overturn rate on appeal? A higher percentage in this category simply reflects that the payer may not have a comprehensive system in place to pay claims appropriately the first time the claims are submitted.

Communicate

Establishing a communication plan helps ensure that denial resolutions are shared with all involved professionals-physicians, providers, practice staff, and payers. Notification should be immediate to physicians and providers. The practice will have greater leverage to reverse the denial while a patient is still under treatment.

The practice should communicate with its payers, too. The practice leader, often the practice administrator, can consider meeting regularly with the top ten payers. Building these relationships will enhance collaboration between the practice and the payers. As the practice gathers statistical data through its denials management process, it can use these data for the next contract negotiations.

Practice staff are often the ones completing the hands-on processing of denied accounts, but they are often the group of professionals missing from communications. The communication plan should address them directly.

Once written policies and procedures detailing the denials management process are communicated, resources are made current, and staff have been trained on the denials management process, then each area of the practice, as well as individual employees, should receive monthly, quarterly, or annual reports that detail denied accounts. This detail should include the activity status, such as accounts due to clerical errors of transposed numbers or inaccurate data entry.

As the practice progresses through its denials management process, it should document roadblocks and track them for resolutions, as possible. Write-offs should be closely monitored to ensure that the accounts receivable statistics are not falsely represented due to either careless or purposeful write-offs by practice staff. Once the practice begins tracking individual denial statistics, it may be surprised by what some staff members will do to make their individual statistics look better than others in the practice.

A practice may even determine that dollars are written off as contractual allowances falsely, which hides problematic issues. Additionally, denial reasons codes such as lack of authorization, lack of precertification, patient not eligible, and past filing limits, to name a few, reflect serious process issues.

In either scenario, if there are written policies and procedures in place, then not all staff members may be following them. If the practice has limited or no written policies and procedures in place for denials management, then it must make this a priority in order to make a positive impact on the financials.

As with any initiative, good intentions may only go as far as the staff can provide assistance. Many practices use consultants to analyze their revenue cycles, including steps in the denials management process such as charge capture, reporting, and appeal processes.

Whether practices tackle their denials internally or with outside help, the best solution is to resolve them. Practices that take the time necessary to understand the denial process and make the necessary clinical or administrative changes to resolve denials will see a benefit to their bottom line.

Note

1. AHIMA. *Pocket Glossary for Health Information Management.* Chicago, IL: AHIMA, 2008.

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