Don’t Deny the Denials: Experts Recommend Implementing a Strong Claims Denial Strategy to Offset ICD-10-based Coder Productivity Loss

By Lisa A. Eramo

As organizations prepare for the implementation of ICD-10-CM/PCS next year, many are looking for creative strategies to mitigate anticipated decreases in coder productivity that will come with the switch. Some are ramping up education, others hiring additional staff members or implementing computer-assisted coding. However, experts say creating a strong denial management strategy may be one of the most efficient and effective solutions for minimizing the impact of productivity loss.

“Anything you can do to prevent re-work will have a significant impact on productivity and the ability to be efficient,” says Mary H. Stanfill, MBI, RHIA, CCS, CCS-P, FAHIMA, vice president of HIM consulting services at United Audit Systems, based in Cincinnati, OH. She says forward-thinking organizations are pushing for a more concerted effort to combat denials, hoping that the long-term effects of doing so will pay off and allow them to keep current discharged not final billed (DNFB) report goals in place even after the implementation of ICD-10. The benefits of a strong denial management program are not limited to ICD-10, but can be used to mitigate current denials under ICD-9-CM as well.

How to Start a Denial Management Program

All organizations—acute care hospitals, long-term care facilities, and physician practices—experience denials. Nobody is immune from this ever-present and growing problem in the industry. The goal is to understand why they occur, identify the root causes, and then do something about them.

“The days of managing denials don’t correct the problem,” says Cheryl Gregg Fahrenholz, RHIA, CCS-P, president of Preferred Healthcare Solutions, based in Bellbrook, OH. “It’s about preventing denials from even happening. Every time a person touches a claim, it costs money to an organization.”

Many organizations are not truly aware of their denial rates or how much it may be affecting their revenue. Unfortunately, many organizations are simply in denial about their denials, says Rose T. Dunn, MBA, RHIA, CPA, FACHE, chief operating officer at First Class Solutions, based in Maryland Heights, MO. “I suspect organizations have been focused on the big dollar denials from the RACs and other similar external review entities,” she says. “However, ICD-10 will force us to look at the small denials for outpatient tests and procedures that may not meet medical necessity or that are rejected or denied because of a lack of specificity.” These are the types of denials that organizations might, at one time, have otherwise ignored. Now, all denials will become important and worthy of closer review because all dollars matter, Dunn says.

Long-term care facilities are going to struggle with denial management and ICD-10 in general, says Deanna Peterson, MHA, RHIA, assistant vice president of health information services at First Class Solutions. This is particularly true for those facilities that aren’t part of a larger healthcare delivery system. Long-term care facilities in general don’t tend to employ certified coders, she says. Instead, minimum data set (MDS) coordinators or entry-level clerical HIM staff perform the coding function. She fears that without proper preparation, these facilities will become buried in denials once ICD-10 goes live. Even despite all of the hype about denials and lower productivity, many long-term care facilities aren’t hiring certified coders, Peterson says. “It’s not an option for some of them because resources in long-term care are scarcer than in any other healthcare setting,” she says.

Peterson anticipates that certified coders will eventually begin to move into the long-term care realm, but only once these facilities realize how damaging denials can be to their bottom line. “If these facilities start receiving denials for unspecified

codes, then the importance of accurate coding really trickles down, and they'll start to realize that investing in a qualified coder is worthwhile," she adds.

"They don't want to pay people to be in that position, but they're going to have to. It's a big dilemma," says Cathy Moore, BS, RHIA, RAC-CT, an independent consultant based in Kettering, OH. Moore's experience working with long-term acute-care facilities has been that many are only just beginning to think about ICD-10 preparations. A coordinated denial management strategy isn't even on their radar. "They just correct denials and send them in. There's no risk management," she says.

The way in which long-term care facilities are paid could be part of the reason why coding and denial management haven't been a priority, Peterson says. "There is a section of the MDS where you have to enter codes, but it doesn't directly tie to the [resource utilization group] RUG score. Their reimbursement is not directly tied to coding as it is in acute care and physician practices," she says.

Bundled payments may change all of this. "We may see the payment structure change, and coding may become more important in long-term care. But regardless, they have to know how to use ICD-10," Peterson says. "It is a requirement that they assign the appropriate principal diagnosis and sequence correctly. From a compliance perspective, they need to assign accurate codes."

As with long-term care facilities, physician practices also struggle with denial management. Many are completely unaware of how this problem will only worsen going forward or why denial management is important in terms of productivity and efficiency, Dunn says. "Physicians may be experiencing a 10-15 percent denial rate on their billed CPTs," she says. "However, with the Affordable Care Act, the participating payers have been encouraged to use more severity- and risk-based reimbursement approaches similar to the Medicare Advantage HCC [hierarchical condition category risk adjustment system] methodology." This means there could be financial implications for providers who don't accurately report the diagnosis code or any secondary conditions, she explains.

Fahrenholz agrees that physicians who outsource their coding may not even know what their denial rates are or why claims are denied because there may be little or no communication and feedback provided to the practice.

Beware and Combat these Various Types of Denials

Establishing a formal denial management strategy led by a denial management task force is crucial for healthcare organizations. Such a strategy must be able to anticipate and mitigate the most common denials that are likely to occur in ICD-9 or ICD-10. Consider the following types of denials that experts say will be particularly problematic going forward and what can be done now to address them.

Technical Denials

Technical denials may occur due to a flaw or problem with claims processing—the sending, receiving, and processing of the claim. These types of denials will be almost guaranteed when ICD-10 is implemented, considering the technical complexity of transitioning to an entirely new and more specific coding system.

Solution: The best way to mitigate technical denials is to ensure that accurately coded test claims are vetted through a formal end-to-end testing process, Stanfill says. Perform end-to-end testing with as many payers as possible to ensure a smooth transition.

Logic-based Denials

Denials for logic-based errors may occur when the ICD-10-PCS or CPT codes don't logically match the corresponding ICD-10-CM code. For example, carpal tunnel syndrome now specifies left or right. The diagnosis code should match any corresponding procedure code.

"In ICD-9-CM, there has never been an edit check for this, but now with the addition of left or right in the diagnosis code… this may change," Stanfill says.

Solution: Hospitals may be able to rely on claims scrubbers to catch these types of errors. However, physician practices with less sophisticated software may have a more difficult time. Coders will need to pay close attention to diagnoses that specify laterality to avoid denials.

Experts say it will be particularly difficult to manage logic-based denials that occur after payers have looked longitudinally across multiple providers. For example ICD-10-CM includes a seventh character to specify episode of care (i.e., initial, subsequent, or sequela). Consider this scenario: A patient with a head injury presents to the emergency department. An emergency department physician first evaluates the patient. Then the patient receives a CT scan that is subsequently reviewed by a radiologist and neurologist. All three physicians must report a seventh character of 'A' for initial. Any deviation from that could raise a red flag. "The payer is really the only one who can see all of these services," Stanfill says. "These types of denials are going to be really hard to wrap your arms around and address. It's an area of concern because we don't have good longitudinal processes even within a healthcare delivery system that spans the continuum of care."

The same is true as payers look across multiple settings. "In theory, the physician's claim and hospital's claim should have the same diagnosis," Peterson says. "If there is a discrepancy, the MACs [auditors] could flag that and question either the hospital's claim or the physician's claim. These errors are so easy for MACs to identify because they can see the whole continuum of care."

Stanfill says that in the future, providers will likely create more coordinated denial management efforts across settings. These multidisciplinary and cross-setting efforts may closely resemble those that are starting to emerge to address readmissions. The ability to data mine via the EHR can help shed light on the problem, she says. "I think that's the next wave of what we need to solve [after ICD-10 is implemented]," she says. "We will begin to see best practices and folks getting creative about how to solve this."

Denials for Unspecified Codes

Although unspecified codes may not have significant financial implications today, many experts fear that this will change in ICD-10. "ICD-10 allows payers to be more specific and targeted in terms of what they will and will not cover," Stanfill says.

Many payers are just starting to publish updated Local Coverage Determinations (LCD) and National Coverage Determinations (NCD), Peterson says. She suspects the volume of coverage-related denials due to a lack of specificity will be highest during the first six months of implementation as organizations absorb this new information from payers. "Payers have an opportunity to revamp entire coverage policies," Fahrenholz says. "You may think you know what's going to be paid, but there are a lot of unknowns."

Unspecified codes may be particularly problematic in the post-acute care setting, says Peterson. That's because staff members either aren't properly trained to identify a more specific code or documentation from the referring facility isn't sufficient. She cites congestive heart failure, unspecified, as a classic example.

Solution: Identify your current unspecified rate today in ICD-9-CM and track it, Stanfill says. An unspecified rate of 18-20 percent with ICD-9-CM is not uncommon, and the goal is ultimately to keep that baseline rate from increasing both today and after ICD-10 is implemented.

"We have more specified codes with ICD-10, so you would expect the unspecified code rate to be lower," Stanfill says. "However, in every case where we've compared ICD-9-CM unspecified code rates to ICD-10-CM unspecified code rates, the ICD-10-CM unspecified code rate is higher. This is counterintuitive to what you would expect and evidence that documentation improvement, targeted to capture the details in ICD-10-CM codes, is necessary."

Moore suspects that long-term care facilities will begin to put more pressure on acute care hospitals to provide specific documentation in their history and physicals (H&Ps), transfer sheets, or discharge summaries. She says some facilities are even starting to develop a formal query process for attending physicians so they can question and clarify hospital documentation, if necessary. One should also monitor any local coverage determinations (LCDs) and national coverage determinations (NCDs) as they are published. Note the unspecified codes that payers will reject for nonpayment. Ensure that documentation is specific so as to avoid reporting these codes.

Physician practices can—and should—closely review contracts with commercial payers, Fahrenholz says. It may be appropriate to revisit and re-negotiate these contracts based on ICD-10. "You want to make sure that the services you provide with the technology that you have will be covered with ICD-10 codes," she says. "CPT tells what you did, but ICD tells why you did it. The 'why you did it' will give the payer an opportunity to revise coverage guidelines, which may result in a denial even if they had paid for a service in the past."

Denials for Invalid Codes

Those organizations that struggle with invalid codes in ICD-9-CM may find ICD-10-CM to be particularly challenging, Moore says. "The denial rates will probably be doubled or even more depending on the experience and training of the coder," she says. "I think it's going to be a billing nightmare especially for those facilities that never gave the proper training to their staff." The recent delay of the federal ICD-10 compliance date gives organizations more time to train coders and ensure they are ready for the new code set. In ICD-10-CM, invalid codes could occur if coders forget to assign sufficient characters or if they forget to include a placeholder for certain injury and fracture codes. These types of errors will be more difficult to spot immediately because coders simply won't be familiar with the new coding system, Stanfill says. Coders may not recognize when a code is incomplete or invalid.

Solution: The hospital claims scrubber may be able to catch these errors, but physician practice coders may not have this luxury. "They may be keying information from a pick list or superbill and not checking the actual code table to validate the code," Stanfill says. Even if the clearinghouse kicks it back to the coder, this still requires rework and slows productivity, she adds.

The best way to mitigate these errors is to ensure that coders receive proper training. Experts say that a denial management program should include a strong coder education component. If codes are assigned correctly the first time around, denials will decrease naturally.

Tips for a Strong Denial Management Program

Consider the following when addressing denials either for ICD-9 coding or in preparation for the implementation of ICD-10:

- **Don't get overwhelmed.** Identify your most common denials and look for trends, Stanfill says. Is documentation sufficient? Are codes accurate and complete? What patterns do you see emerging, and why? Organizations don't need to reinvent the entire wheel. "It's likely that some of the denials you're facing under ICD-9 will move over to ICD-10 as well," Peterson says. Figure out what strategies work well today, and be sure to continue those in ICD-10.
- **Capitalize on coding staff members.** Some organizations are including a coder in the scheduling department so they can ensure that the correct and complete code is obtained during the pre-certification process, Peterson says. This can help combat medical necessity denials and ensure accuracy from the start of the registration process.
- **Plan ahead for cash reserves.** Even despite an organization's or payer's best efforts, denials or delays in the short-term are bound to occur. The big unknown is for how long. Organizations need to be able to cover their expenses for at least three months and ideally six months after the implementation of ICD-10 in the event that payments are delayed or come to a complete halt, Fahrenholz says. Identify each payer's current lag time for paying various claim types (i.e., inpatient, emergency department, outpatient), and assume that this timeframe will increase in ICD-10, she says.

Payer readiness continues to be a problem, Peterson says. "What we're hearing from the industry is that there are very few payers who are attesting to the fact that they won't be ready for ICD-10," Patterson said before the recent ICD-10 delay was announced. "What we're getting is either a 'no response' or a 'to be determined." It is unclear if payers will use the delay to catch up on their implementation efforts or continue to procrastinate. Payers that struggled with the HIPAA 5010 transition will likely also struggle with ICD-10, she adds. These are the payers that should be on every organization's "watch list."

When thinking about cash reserves, identify the payers who've yet to provide a clear response for readiness and keep an eye on them during the build up to the October 2015 compliance date. Look at your volume of claims for each of these payers and then plan for a three to six month lag time for payment once ICD-10 becomes effective. Some organizations may need to investigate a line of credit to help offset any lost revenue, Peterson says.

Lisa A. Eramo (leramo@hotmail.com) is a freelance writer and editor based in Cranston, RI, who specializes in healthcare regulatory topics, HIM, and medical coding.

Article citation:
Eramo, Lisa A. "Don’t Deny the Denials: Experts Recommend Implementing a Strong Claims Denial Strategy to Offset ICD-10-based Coder Productivity Loss" *Journal of AHIMA* 85, no.6 (June 2014): 30-33.