How to Battle Coding Denial Trends: Creating a Proactive Appeal Strategy

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As healthcare moves toward value-based reimbursement, provider organizations are experiencing a new level of complexity in coding denial trends, which requires effective strategies for managing denials and appeals. Though denial prevention is the ultimate goal, denials remain a reality for health information management (HIM) directors and dedicated staff.

Among recent trends, claim denials from Medicare, Medicaid, and commercial payers are on the rise, with a steady increase in commercial denials. In fact, 80 percent of denials are now from commercial payers. Furthermore, the median for successful appeals for hospitals fell to 45 percent for commercial payers and 41 percent for Medicaid, according to an Advisory Board report.[1] Awareness and understanding of emerging trends is the first step toward creating a proactive appeal strategy that promotes optimal outcomes and most effectively battles denials.

Heightened Focus on Clinical Validation

Distinguishing coding denials from clinical validation denials is an ongoing challenge. HIM professionals are seeing more clinical validation denials, especially where payers use a combination of clinical and coding references, making it hard to determine the type of denial. In some cases, a coding reference may be used inappropriately to support a clinical validation. This is a growing issue that demands a dual approach to writing appeals. Coding experts—who specialize in coding rules and regulations—and clinicians—nurses, physicians, nurse practitioners, physician assistants—should work together to appropriately respond to denials. Collaboration between coding and clinical documentation improvement (CDI) professionals is essential.

Even when provider documentation clearly states a diagnosis, it will be challenged if the payer determines there are insufficient clinical indicators or discussion points to support the diagnosis.

Shift from Inpatient to Outpatient Denials

As more and more hospitals acquire and manage physician practices, the shift toward increased outpatient denials is a new and challenging trend. In these cases, there's virtually nothing regulating payers, and the lack of oversight results in inconsistent timelines, difficulty getting responses, and overall ambiguity about the denial. The lack of clarity regarding what specifically is being denied makes the appeal process more difficult.

On the inpatient side, the cost to appeal—typically hundreds of dollars—is nominal compared with what could be recouped. Moving into the outpatient realm, at the physician practice level, for example, the recoupment amount may be relatively low—less than $150. For this reason, it is important to consider the value of pursuing an appeal and to establish criteria around the process. Is it worth the time and effort? Regardless of the cost and potential gain, tracking all denials is important in order to understand what payers are targeting and to leverage that information to educate physicians and allow coding and CDI professionals to focus on high-risk areas.

Higher Volume of HEDIS and Risk Adjustment Requests

Payers are requesting larger volumes of records for Healthcare Effectiveness Data and Information Set (HEDIS) and risk adjustment purposes, placing unprecedented demands on HIM staff. There seems to be a fallacy that minimal effort is involved in producing health records within an electronic environment. Furthermore, many payers are now requesting direct access to the electronic health record (EHR), a controversial issue from both a data management and privacy/security perspective.

From an HIM perspective, managed care contracts should include language that limits the number and types of medical record requests at no charge—and requires accountability on the part of the payer. For example, if the payer says a claim is not substantiated based on the DRG submitted, then timelines should be in place to ensure clarity about what is being denied and why. Support from senior leadership is critical.

Queries and Review Dates Subject to Payer Scrutiny

In an effort to identify gaps in documentation where an additional physician query may be necessary, payers have heightened their scrutiny of queries. It's important to make sure the queries are complete and appropriate. Here are three recommendations:

- Create templates to ensure queries are standardized and not leading.
- Include queries and the physician response in the designated record set/legal health record.
- Follow appropriate guidelines that were applicable to the date of the claim.

  In some cases when there are post-payment reviews, the payer may erroneously reference guidelines effective at the time of review but not in effect at the time of service. If appropriate guidelines are not applicable to the claim date, the findings should be challenged as part of the appeal process.

Technology, People, and Processes Protect Revenue

Data collection and reporting are critical to an effective denial management program. At Yale New Haven Health, a large hospital and physician network based in Connecticut, denial management and appeal technology has been implemented and combined with a team of experts to manage the volume of denials and pursue the appeal process across the system. This dual approach is designed to help the organization eventually move from payer denial management to proactive denial prevention. Yale New Haven Health has made substantial progress through comprehensive reporting capabilities that enable tracking and monitoring of essential metrics via a centralized dashboard, including:

- Number of denied cases—how many appeals for each
- Top denied reasons by payer for fiscal year
- Payer outliers—supports conversations with payers regarding issues
- Overturned cases by last level of appeal
- Upheld cases by last level of appeal—keep fighting to the last level
- Top DRGs targeted whether upheld or overturned—identifies key issues
- Recovery Audit Contractor (RAC) appeal summary—audit dashboard showing dollars recovered
- Open cases—indicates new appeal volumes by payer for trending purposes
- Volume by appeal level—current cases in progress
- Percentage of upheld versus overturned appeals

These reports identify initial dollars at risk, dollars recovered, problem payers and DRGs, and more. In addition to standard reports, the system provides unlimited ad hoc reporting based on specific filters to produce customized reports. It is a data-rich system that captures critical data. One of the most important benefits is the ability to identify the root causes and frequency of payer denials and provide education on the front end of the revenue cycle.

Implementing a Proactive Appeal Strategy

With the increased volume of denials from all payers, health systems need strategies to proactively address and appeal denials. Here are six proven practices to consider:

Establish a multidisciplinary team approach. Include representatives from critical areas—HIM, physicians, coding, CDI, managed care contracts, revenue cycle, legal, financial, audits, and compliance. Hold regular meetings to review reports, discuss issues, track trends, and monitor outcomes. For example, look at the top 10 DRGs targeted. Identify opportunities to improve education. Knowledge sharing is necessary to achieve clinical and financial goals.

Work closely with the managed care contract department. Managed care contractual provisions affect payment, departmental organization, billing procedures, and clinical decision-making. Providers need to understand contract language and exercise their rights in the appeal process. Initiate conversations about opportunities to change some of the language in contracts with payers. Given the traditional structure of contracts, the focus on medical records has been lacking. Contracts are usually written in favor of payers. Meet with contracting to revise the language to support the appeal process.

Promote communication among all stakeholders in the denial and appeal process. This includes HIM, coding, CDI, contracting, compliance, finance, and clinicians. Transparency of data and trends is critical as the impact of denials affects all aspects of the revenue cycle. In addition, with the growing volume of denials involving a combination of clinical and coding issues, CDI and coding must collaborate to ensure correct coding and clinical documentation on the front end and proactively educate physicians.

Consider engaging a physician advisor to support the appeal process. A physician advisor is a valuable partner who can help with many aspects of the appeal process, particularly clinical validation, and also provide education for other physicians on documentation best practices that help prevent denials and pursue appeals.

Do not assume that a denial is correct. An appropriate credentialed individual should be involved in the denial process. Check for a signature by a clinician or certified coder. Investigate the rationale for the denial. Make sure coders are up to date on all coding resources. Verify all references including AHA Coding Clinics and other resources and ensure each reference is applicable to your case. Note any discrepancies in your appeal.

Provide periodic training for all stakeholders. Conduct ongoing training and provide educational resources related to denials and appeals. Use reports to develop educational opportunities aligned with tracking and monitoring trends. Continually evaluate your appeal process and revise educational efforts accordingly. Build on strengths and identify any weaknesses that need to be addressed.

Awareness of coding denial trends helps ensure best practices to address denials and pursue appeals. The claims appeal process is costly, time consuming, and increasingly complex. Ideally, healthcare providers will implement strategies to successfully manage the process and move toward prevention.

Note

1. Advisory Board. "Hospital Revenue Cycle Showing Strength But Risks Include Denials." November 14, 2017. www.prnewswire.com/news-releases/hospital-revenue-cycles-showing-strength-but-risks-include-denials-300555731.html.

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Article citation:
Powers, Malissa. "How to Battle Coding Denial Trends—Creating a Proactive Appeal Strategy." *Journal of AHIMA* 90, no. 3 (March 2019): 16–19.

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