Improving Cash Flow in a Down Economy: How HIM Can Help Reduce Denials

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Maybe HIM professionals can't ease tight credit or reduce bad debt, but they can make sure their organizations get full, correct reimbursement on the first submission. HIM professionals help improve cash flow by contributing to revenue cycle management.

In these tough economic times—when increases in bad debt are expected to parallel the rising loss of jobs and health insurance—a provider's cash flow is more important than ever.

And it isn't just the down economy putting pressure on providers. Other forces are at work. Increased external reviews by recovery audit contractors, Medicaid auditors, and other third-party payers; decreased reimbursement; and rising costs of patient care technologies force any entity to focus on receiving its entitled reimbursement.

More than ever, the importance of the health information manager's role in revenue cycle is apparent. Health information managers, coding professionals, and release of information specialists play pivotal roles in improving cash flow by reducing denials and ensuring clean claims on the first submission.

Defining Denials

Denied claims are not bad debt.[1] Bad debt results from charges that are unpaid by patients. Third-party insurers deny claims. Common reasons include:

- Services billed are not covered by the healthcare plan.
- Claim was not submitted to the insurer in a timely fashion.
- Claim was submitted to the wrong insurer or to the right insurer but at the wrong address.
- Claim was previously submitted and has already been paid or denied.
- Services billed do not meet medical necessity criteria established by the payer.
- Supporting documentation was not provided or was insufficient to support the services billed.

Denied claims are not rejected or suspended claims. Rejected claims fail to match the patient with an enrollee or contain incomplete or inaccurately formatted data. A common example for HIM is a CCI edit rejection. Rejected claims therefore are not "clean" and do not pass the payer's processing requirements.

Suspended claims are rejected claims that have been placed in a provider-accessible file so that the provider can make the changes necessary for the claim to clear the payer's processing requirements.[2]

Claims may be partially or totally denied. For example, a patient is treated as an inpatient and discharged. One item on the resulting claim includes discharge drugs that could have been obtained without a prescription at the local pharmacy. The health plan does not pay for medications that are issued to the patient as a "take home" medication regardless of whether it is a prescription or over-the-counter medication. In this case, all other charges are paid, but the line item for the discharge drugs is denied.

Another example is a common Medicare requirement that certain surgeries be performed in an inpatient setting only. A claim submitted for one of those surgeries performed in an outpatient facility will likely be denied in its entirety. The payment

received in the first example will be less than expected and zero for the second. Both are situations that concern the chief financial officer, who learns that expected payment has been denied.

Many facilities find that the majority of their denials are caused by administrative errors related to eligibility and authorization, followed by clinical errors caused by incomplete physician documentation.[3] Coding professionals are valuable resources when it comes to submitting clean, error-free claims because they can identify missed charges and mischarges as well as assess the documentation (or the lack thereof) to support the charges.

How HIM Professionals Help Denials Management

HIM professionals can help ensure clean claim submissions through their experience in documentation and coding:

- Data analysis—identify denial trends not apparent in the aggregate data
- Charge review—identify discrepancies between supplies ordered and procedures documented as well as identify misplaced and missed charges
- Training—teach access staff basic coding skills to facilitate their ability to accurately assess medical necessity for the test being ordered
- Back-end editing—process claims through back-end editing applications to identify claims with codes that might not support medical necessity
- Documentation improvement—establish documentation improvement programs, employing a mix of clinical and coding professionals to address deficiencies
- Release of information—provide timely copies of patient information to support the claim when requested by the insurer

Finding the Problems

The two examples above illustrate a general truth. Nearly all denied claims are the result of failure to validate coverage for the services rendered. These denials are considered "provider's fault" claims.

The first example points to a need for additional education for the patient care and pharmacy staffs. The second example identifies necessary procedural changes for access and scheduling or possibly addition of a system alert when a restricted procedure is scheduled in the wrong setting.

Patient financial services staff are the first to know when a claim has been denied. This typically surfaces on the remittance advice received 15 to 45 days after the claim has been submitted.

The first step in managing denials is understanding why they are happening. Therefore, it is wise to categorize the reasons in the patient financial services system or other decision support database in such a way that trends can be identified. The number of reasons established should be kept to a manageable amount, such as 20 or less. Having too many reasons will focus staff on minutia and distract them from seeing trends. The goal is to look for conditions that have common sources and symptoms.

Creating a Team

Once a history of denials has been collected, a denials management team can review and assess where the systemic issues lie. The team can then address the issues by identifying processes in need of modification and staff in need of training or retraining.

For example, a facility tracks a rise in denials for MRIs, and 70 percent of the denials are for MRIs ordered by Dr. Jones. In this situation education is appropriate for the access department, MRI scheduling area, and Dr. Jones (or his office staff).

Health information managers are good candidates to provide the education. They have the competencies to teach access and scheduling staffs how to use the organization's advance beneficiary notice (ABN) software effectively. This may include providing a list of diagnosis codes commonly used by the physicians ordering the tests.

The organization's education department can offer training to bolster the access team's customer service skills, since these individuals must present and explain an ABN to the patient. They can provide training to bolster the registrar's ability to collect patient co-pays or deductibles in advance of service, thus reducing the potential for bad debt later.

Finally, the physician must receive sufficient information on the medical necessity rules, how to properly prepare a complete order for an MRI and other tests, and conditions that are covered by the third-party payers serving the majority of the patients treated at the institution.

Jackie Hodges, RHIA, offers the following advice to avoid denied claims:

"Hospitals should ask the following questions about the services they provide to Medicare beneficiaries:

- Under what conditions is payment made for this service?
- How and to what degree will the service be covered?
- What type of staff certification is required to render the service?
- What ICD-9-CM and/or CPT/HCPCS codes are approved for use?
- What modifiers, if any, apply to the procedure codes?
- How is the billing unit defined for the service?
- Are there limits on how many units may be billed for a particular service?
- What revenue codes may be used to bill for this service?
- Are certain providers prohibited from providing the service?"[4]

The denials management team should include representatives from surgery scheduling, utilization review, case management and discharge planning, compliance, access, health information management, and patient financial services. It is equally beneficial to include representatives from those departments that capture and generate charges. The denial management team may benefit from training in Six Sigma process improvement tools, which can be excellent for investigating and eliminating the cause of denials.

Benchmarks are helpful, too. In 2007 the Healthcare Financial Management Association published metrics that indicated denial rates should be no more than 4 percent of gross revenues and that 40–60 percent of denials should be overturned.[5]

The denial management team should establish goals and use benchmarks such as those. The team can evaluate its progress toward goals monthly and assess whether the changes implemented have reduced the denial rate.

Successes should be celebrated. When the percentage of denials in a category is reduced or eliminated or the appeal success rate increases, the denial management team and respected charge capture or generating departments should be recognized.

Recognition can be demonstrated in different ways, including monetary bonuses, celebratory lunches, or increased budgets for departments to use in education or other improvements. Recognition may be as simple as posting the team's successful progress prominently for others to see.

How HIM Can Help

HIM professionals can enhance the denial management process and facilitate clean claim submission and contribute to reducing days in accounts receivable through their experience in documentation and coding.

Data analysis . HIM expertise in data collection and display often assists the denials management team in seeing aberrations that were not apparent from the aggregate data. Facilities have begun assigning denial data analysts to perform this role. These analysts require the skills consistent with AHIMA's new health data analyst credential.

Missed services . Coding professionals with access to the charges for the accounts they are coding can ensure that all services requiring coding are captured. They may notice a discrepancy between supplies ordered and procedures documented.

For example, a physician may have performed a bedside debridement but failed to document it in the progress notes. The consent form, although signed, was not placed in the record; it drifted into HIM several days after the coder reviewed the record. The coding omission in these circumstances is understandable but avoidable if the coder had had access to the charges, which would have included the surgical supplies on a given date.

Missed and misplaced charges . In addition, coding professionals can review charges to identify misplaced and missed charges. Reviewing charges helps avoid a line-item denial for a surgical supply charge on a claim that does not contain procedures. Similarly, filing a second claim to obtain charges that surface later may result in a denial for untimely filing or duplicate billing, which may require the provider to send additional documentation in support of the claim's late charges.

Coding professionals can provide guidance for physicians, access staff, utilization review coordinators, and case managers on the documentation required to support medical necessity for both inpatient and outpatient services.

Training . Access staff must have basic medical terminology and anatomy skills. Health information managers can teach access staff basic coding skills to facilitate their ability to properly recognize valid conditions on physician testing orders and accurately assess whether the condition qualifies as a medically necessary condition for the test being ordered.

Failure to perform this qualifying step and obtain advance beneficiary notices of noncoverage (ABN) for those tests that are not medically necessary will result in extra work later by both HIM and patient financial services. HIM coding and support staff must follow up with physicians to determine if there were other conditions present that triggered the physician's order for the test.

Back-end editing . HIM staff can process accounts through back-end editing applications to identify accounts with codes that might not support medical necessity. Doing so before the account transfers for billing will save time for the coders because the record is readily available for re-review and, if necessary, the physician can be contacted. This approach saves rework later and contributes to reducing denials and days in accounts receivable.

Documentation improvement . Since some denials are the direct result of inadequate documentation, HIM professionals can establish documentation improvement programs, employing a mix of clinical and coding professionals to address deficiencies with clinicians including physicians to ensure the documentation tells a complete story as well as provides sufficient documentation to support all entitled reimbursement due.

Release of information . Finally, HIM can stem denials and reduce days in accounts receivable by providing timely copies of patient information to support the claim when requested by the insurer. Monitoring mechanisms can prioritize insurer requests for claim validation—not above continuity of care, but high on the pecking order.

Managing Appeals

Denied claims require a prompt review to determine if there is an opportunity for appeal. Denials should be promptly routed to the correct departments: denials due to coding should be routed to the coding manager, denials for admission or length of stay should be routed to utilization review or case management, and so forth.

Managers should establish an expectation of review within two working days. Since denials are typically received by patient financial services, this department should serve as the central coordinator of denial logging, categorizing, and routing. To ensure timely appeals, the denial coordinator should ensure timely distribution to the responsible parties and follow up should there be a delay in receiving their response.

One person must be designated to receive and read all payer newsletters. This person should raise payer-announced changes at denial management team meetings, where the team can determine how the changes will affect the organization. If payer changes are captured effectively, appeal letters can incorporate information from payer newsletters as well as timeframes for rule enactment that may have occurred subsequent to the date of denied service.

Preparing and writing an appeal takes time, and it requires researching the background of the denial. The appeal writer must provide concrete proof that the organization is entitled to the denied payment. This may require presenting information that was not provided with the initial claim; however, some insurers will not allow a second or supplemental submission. The appeal should be reasonable; that is, it should be based on a payer's misinterpretation, not the organization's error.

An appeal letter may include the following items:

- Description of the facility's qualifications and its commitment to complying with regulations and providing appropriate services
- A detailed account of the patient's treatment
- Cross-reference of the treatment described to the claim and the copy of the patient record provided
- Description of the patient's medical history and patient's complaints addressed during the encounter
- Connection between the treatment provided and the medical history and patient's complaints
- Explanation of how the treatment provided is consistent with accepted treatment patterns and, if necessary, citation or copies of relevant journals or other materials from medical societies and recognized practitioners
- Illustration of how the treatments benefited the patient and, if available, supportive articles from the payer's newsletters
- Acknowledgment of lags in rendering services that extended the length of stay because of facility operational issues, not medical reasons[6]

Monitoring the Progress

Managing appeals extends to tracking their status. The process requires an effective tracking method to monitor the progress of denial decisions and appeal preparations within the organization as well as the status of the appeal with the insurer.

When mailing the appeal, delivery services allow organizations to know when the appeal has been received by the insurer and who signed for it. Follow-up with the addressee of the appeal to confirm receipt.

Be certain to monitor the timeliness of appeal processing by knowing the timing rules of the payer and submitting materials and appeals well within the timeframe established. The denial management coordinator needs to be persistent in this role.

As discussed earlier, denials should be categorized so that trends can be identified and any positive progress from your performance improvement measures can be demonstrated. Components of the denial database should include:

- Denial date
- Account number
- Denial reason: clinical, technical, coverage, etc.
- Payer
- Service area: registration, scheduling, laboratory, inpatient, etc.
- What was denied: entire claim, line item
- Denied CPT, HCPCS, or revenue code
- Denied charges amount
- Total charges amount
- Percent of charges denied
- Physician
- Denial assigned to whom for investigation (case management, HIM, patient financial services, etc.)
- Appealed: yes/no
- Date appealed
- Denial reversed: yes/no
- Amount of denied charge recovered

In smaller organizations this information may easily be handled through a database application or even a spreadsheet. Larger institutions may require a more robust application designed specifically for the purpose.

The overall direction of the organization's denial management process should be in the C-suite. While it may be natural to place this responsibility with the CFO, the chief compliance officer or chief operating officer could be an appropriate executive. If the C-suite lacks interest in denial management, the efforts at the middle-leadership level may wane or fail. There must be a senior executive champion of the process and one who publicly recognizes the progress of the team.

The executive leader also must take care to reduce the potential of underreporting denials. If reporting denial frequency is housed in patient financial services, there could be hesitancy to report the number of denials due to untimely billing.[7] Similarly,

one might see the same degree of hesitancy to report denials due to coding if the denial database is managed by HIM. Thus, the executive leader must instill an atmosphere of process improvement, not one of blame and punishment.

Successful denial management requires facilities to seek both prevention and recovery. Recovery is a quick fix, but without diligent oversight of payer initiatives and internal process changes, organizations will not prevent denials from reoccurring. HIM professionals are ideally positioned to help reduce denials by identifying denial trends and serving as principal educators for those areas where denials are common.

Notes

1. Healthcare Financial Management Association (HFMA). "P&P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Providers." December 2006. Available online at www.hfma.org/library/accounting/reporting/ppb_charity_bad_debt.htm.
2. Waymack, Pam, et al. *Denial Management: Key Tools and Strategies for Prevention and Recovery*. Marblehead, MA: HcPro, 2005.
3. HFMA. "Tip Sheet: Medical Claims Denial Management." Available online at www.hfma.org/library/revenue/denials.
4. HFMA. "Medical Necessity Denials: Prevention Pays Off," p. 4. Available online at www.hfma.org/library/revenue/denials.
5. Hammer, David C. "The Next Generation of Revenue Cycle Management." *hfm Magazine* July 2007: 52.
6. Adapted from Waymack, *Denial Management: Key Tools and Strategies for Prevention and Recovery*, p. 58.
7. HFMA. "HFMA Executive Roundtable: How Well Is Your Staff Positioned for Denials Management?" Available online at www.hfma.org/library/revenue/denials.

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