



Financial Health > Cash Flow > Operational > Margin Management > Customize > Flexible
46#238-128#126836#23#89047+#34899=127#23#7836%0278=2345980#23578%2354897#123

MedAssets[®]
revenue solutions Net Revenue Systems

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

Industry Landscape

An aging U.S. population is fueling increased demand for hospital beds and healthcare services. However, with several years of shrinking margins and falling bond ratings for many hospitals, financing their futures can prove difficult. Improving the corporate bottom line requires that hospital leaders respond quickly to revenue integrity issues. The quality of the key financial ratios such as revenue, productivity, margin, and days in accounts receivable will be impacted by the integrity of the underlying data utilized to generate these results.

Claims denials management represents a significant opportunity for revenue cycle cash flow improvement and has become a critical component of a healthcare provider's strategic effort toward this goal.¹ Denied claims can typically account for 1% to 3% of net revenue potential for the average hospital. While the impact to the financial bottom line is substantial, it largely remains an untapped opportunity for most healthcare providers. Industry studies report that fifty percent of denied claims are never re-filed, ninety percent of denials are preventable and sixty seven percent are recoverable.²

The Truth about Denials

Traditional denials management methods have targeted the retrospective recovery of actual denied claims without a clear understanding of the magnitude of the issues, how to address these issues, and how to determine if the action steps are effective in preventing future denials.

As a result, healthcare providers continue to experience repetitive revenue leakage and rework of healthcare claims for the same denial issues. The issue is further compounded by the designation of patient financial services as the department responsible for addressing these claims, even though they are not the primary generator of the denied claims and do not have the information necessary for effective resolution. This very labor intensive and nonproductive activity is one of the main reasons that many claims are never re-filed. Ineffective denials management leads to decreased cash flow, an endless loop of nonproductive activities and an unstable payment foundation.

Current denials management models will not succeed as long as providers are unable to place action and accountability at the point of service that triggered the denied claim, assess the results of actions taken to make timely adjustments to the processes, and see the big picture impact of the entire process.

¹ "Transforming the Revenue Cycle", Guyton, E. & C. Lund, Healthcare Financial Management, March 2003.

² "Capturing Lost Revenues", Health Care Advisory Board Cost and Operations Presentation, 2002, The Advisory Board.

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

With such a significant portion of revenue at risk, the good news is there are solutions available that can deliver an ongoing annuity of recoverable revenue to improve the bottom line, all the while remaining compliant with third party payer requirements.

This article includes several key areas that should be considered when evaluating the effectiveness of a denials management program.

- ❑ A denials management program that will improve cash flow should include a prospective-prevention process to avoid claims denials and a claims-recovery process to address claims that have already been denied.
- ❑ Communicating the magnitude of the problem to stakeholders and providing a means to address the problem is key.
- ❑ Standardization of revenue cycle processes from start to finish will enable autonomy and accountability of key players and reduce errors that result in denials.
- ❑ Technology will play a pivotal role.
- ❑ The goal of denials management is ultimately to increase the providers' ability to predict revenue collections.

Denials Management - Key Areas to Consider

Asset Management - Cash Sooner Rather than Later

Cash flow management is a key factor in any organization's success. Changing the belief that all denied claims are addressed through account receivable management is the first step to improving cash flow. A common misperception is that a reduction in A/R days is a direct result of an effective denials management program. The exact opposite may be true.

First, industry studies show that fifty percent of denied claims are never re-filed. Most of these claims are never analyzed to determine if recovery is possible. This lack of analysis, regardless of the reason, leads to a claim that is written off in the account receivable system. The reason for the write off is often not related to the original denial issue, and the critical issues that triggered the denials are lost and destined to be repeated.

Second, the ability to see all denied claims in the accounts receivable system is limited to the actual payment data from the third party payer that is posted to the hospital's financial system. Most financial posting systems extract high level claims information to post to the A/R system. This high level information will show partially denied claims as non-covered services when, in fact, they are true denials where dollars can and should be recovered. This finding is particularly true for outpatient claims. One 500 bed hospital implemented a denials management initiative as a part of a larger revenue integrity program. A baseline assessment of denied claims identified a high number of outpatient claims that contained partial denials that were in some cases being written

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

off and in other cases were being passed on to the patient as their responsibility. Under their new automated denials management program, the organization now had the ability to see the actual partial denials and quickly address both the lost revenue and patient public relations issues. Within seven months the organization reduced the outpatient denied claims rate from 18% to 7.4% of submitted charges.

The solution to improved cash management for denied claims is a comprehensive interactive denials system that includes completed detailed denied claims information received from the organization's electronic third party payer payment data files and all analysis, actions and resolutions associated with each claim. This type of system prevents the "lost" denials and ensures accountability and authentication of results.

At any point in time, an organization should be able to query the database to determine:

- The volume of denials and a distribution statistics based on claims status such as the number of claims resolved, reopened, re-filed, closed, etc.
- What is the average age of an unresolved denied claim?
- What has been the trend for the last 12 months in terms of the ratio of denied claim dollars to submitted claim dollars?
- What has been the revenue impact of the denials management program?

Any denials management program that will ensure cash flow improvement should incorporate two parallel processes: 1). a prospective-prevention process to avoid claims denials and 2). a claims-recovery process to address claims that have been denied.

Awareness is Required for Change to Occur

The power of an effective denials management system is the ability to easily generate immediate awareness of the magnitude of the problem to achieve stakeholder buy in and provide an efficient means for these stakeholders to address the issues in a timely manner.

A healthcare facility usually has the ability to generate a "list" of denied claims and approximate the lost revenue opportunity. However, the data is often manually generated, subject to errors and incomplete as to the magnitude of the problem. In addition, the amount of manual effort required to generate these lists leaves little time for communication between patient financial services and the various departments that generated the denied claim. In an attempt to foster communication, departments engage in e-mail and voicemail volleyball with old "lists" and new "lists" moving back and forth until the results of the efforts are *lost in translation*.

A 554 bed hospital system established a denials management process utilizing internally generated worklists from the A/R system for the first year. At the end of that time, the team concluded that much effort had gone into the development of the lists, many meetings were held, many claims

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

were re-filed, but no one could say for certain what the impact of the project was on cash flow and process improvement. The decision was made to convert to an automated denied claims system utilizing the third party electronic payment data. The initial snapshot of one month of data for only one payer (representing 40% of the facility's book of business) revealed current denied claims totaling \$1.6 million with an approximate 50/50 split between inpatient and outpatient claims. The annualized impact for this single payer in terms of claims to be reworked was \$19.2 million, despite the organization having a process in place for one year. The organization quickly determined that (a) the current processes were incomplete in terms of denials identification, (b) were very labor intensive in day to day management and (c) the results of previous actions taken were not having a lasting impact on preventing future denials. Stated another way, *"you can't manage what you can't see."*

An effective interactive denials management system provides the ability to quickly identify and quantify denial issues from third party payers while simultaneously allowing for the resolution and results reporting of those issues. The sheer volume of denial data will allow unlimited reporting opportunities, and it is important to remain focused. The initial issue identification should include important baseline information such as:

- The volume of denials by patient type (inpatient versus outpatient).
- The volume of denials by total claims denials versus partial claims denials.
- The volume of denials by denial reason codes.

Once a baseline set of data is established, the magnitude of the problem begins to come into focus. It now becomes critical to categorize these numerous denial reason codes into defined denial groups so that effective and efficient management and reporting can occur. As an illustration, an organization may be receiving 30 unique denial reason codes that all relate to "Coding" issues and 57 unique denial reason codes that all relate to "Patient Registration" issues. While each individual reason code will not state the true extent of the revenue cycle problem, an aggregation of "like" denial reason codes into unique "denial alert" categories provides immediate clarity on the key issues to address and where to steer management activities. The organization is now in the position to quickly get the right message to the right people.

Awareness and trending of denials information is now expanded from the initial baseline issues noted above to questions such as:

- What are the top 5 five denial alert categories impacting our organization?
- Who are the top 5 payers impacting the organization in terms of claims dollars denied?
- What are the top 5 departments/service areas most impacted by denied claims?

Autonomy & Accountability is Required at the Point of Service that Triggered the Denial

Revenue integrity depends on compliance with proper revenue cycle processes from the point where the patient is referred to the organization to the payment of the claim. These processes function

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

sequentially to produce the desired patient outcome and to generate the bill for services related to that outcome. Each process adds critical information along the way to contribute to a total picture of the care rendered and the cost of that care to the patient and/or the third party payer. If any of these processes are not functioning properly, mistakes may become compounded along the way, leading to denial of the claim. This can take the form of one or several denial issues per single claim. The inaccuracies that cause claims to be denied typically are generated from multiple locations in the hospital and, thus, usually are present in claims before they reach the business office.

Staff members, particularly those who serve on multiple units, are now expected to understand fully the various third party payment rules, yet all too often they lack sufficient training to fulfill this expectation. Moreover, these changing payment requirements has shifted responsibility for coding and billing to employees who traditionally have not performed these functions, exacerbating problems with data integrity that are due to employees' lack of training or experience.

For autonomy and accountability to become a reality, it is essential to standardize processes so that consistent measurements and monitoring occurs. Guidelines should be developed for each Denial Alert Category defined earlier. At a minimum the following parameters should be defined.

- Point of Service responsibility - removes any ambiguity as to who is responsible
- Appropriate Action Options - provides consistency in addressing "like" issues across the organization/healthcare system
- Criteria to Classify a Denial as Closed - ensures all denied claims are addressed and prevents inappropriate write-offs and lost revenue.

Any department manager, at any point in time, should be able to easily generate key denials management reports to both assess and address all relevant denial issues. Some meaningful reports to consider include:

- Department ranking in relation to denied claims as a percent of the organization's total denied claims.
- Frequency distribution of denials by Denial Alert Categories
- Frequency distribution of denials - Claims Level(Complete Claims Denials) versus Service Level (Partial Claims Denials)
- Aging Reports for Open/Unresolved Denials Issues
- Departmental denied claims, results analysis reports including the following parameters: payer, denial alert categories, actions taken and status of the claims.

The effectiveness of point of service denials management will be directly related to the level of autonomy and accountability afforded these department managers. Well defined denials management business rules in an automated denials management system allows department managers ready and easy access to key information for real time analysis and management of their

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

respective denial issues. All departments, including patient financial services, will see improvement in both productivity and positive denials management revenue results.

Automation of Denials Management Processes Will be Essential

The volume of denied claims and the regulatory issues associated with these denied claims mandate that technology play a pivotal role in the denials management process.

A well-designed denials management system will electronically gather all denials into an interactive database for distribution and reporting. An effective system will include comprehensive, parameter driven management reports that are easily generated by any member of the denials management team. Automated workflow processes are driven by an organization's business-directed logic to improve efficiencies in denials trending, action steps taken and results reporting. Denials and all actions associated with them are never lost.

Denials management issues require effective interdepartmental collaboration and an effective denials management system breaks down the silos and allows all stakeholders to contribute via their own area of expertise. Equipping the healthcare staff with an automated denials management system provides another powerful revenue cycle tool in the management of the organization's cash flow. The synergies and efficiencies gained through an effective denials management process along with the financial results achieved are real. Initial net recoverable revenues identified through an effective automated denials management process have allowed healthcare providers to realize anywhere from 4 to-10 times their initial cash outlay within the first twelve months of use.

Authentication of Results is Necessary to Assess Current Program Effectiveness

The real goal of a denials management program is to establish and execute activities that increase the provider's ability to predict revenue collection. The accuracy of these predictions is impacted by the organization's ability to authenticate the results of ongoing denials management activities.

A successful authentication process will include the development of relevant and actionable denial intelligence in order to continually evaluate the magnitude of the problem and the effectiveness of actions taken both in terms of retrospective recovery and prospective prevention. This analysis should consist of both external benchmarking and internal results analysis. Authentication metrics can be exhaustive and initially should be limited to those key measures that will allow for reliable and real time resolution of major denial issues impacting the organization's bottom line.

*Denials Management:
Key Assessment Steps to Prevent and Recover Repetitive Revenue Leakage*

External benchmarking in the denials management area is in the early stages as compared to other health care revenue cycle key performance indicators. Several key performance indicators for external benchmarking include:

- Overall denied charges as a percentage of gross revenue - less than or equal to 4%
- Clinical denied charges as a percentage of gross revenue - less than or equal to 5%
- Technical denied charges as a percentage of gross revenue - less than or equal to 3%

Internal results analysis will be the true validation of how effectively the organization's denials management structure, systems and processes are functioning. These key performance indicators will include both revenue improvement and productivity measures. Several examples of internal results indicators include:

- Denied claims re-file rate
- Denied claims success rate
- Revenue recovery results associated with success rate
- Denied claims failure rate
- Lost revenue opportunity associated with denied claims failure rate
- Denied claims aging report by denials alert category
- Denied claims aging report by department/workgroup

Many healthcare organizations are having difficulty in determining whether their current denials management program is effective. If your organization cannot easily generate and address the key questions posed in this article - the time for denials management structure, process and system improvement is *NOW*.