Denial Management Pays Off

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Recent reports have demonstrated that denials are on the rise. Nearly 15 percent of all claims submitted to private insurance companies for reimbursement are initially denied. Though half of those denials are eventually overturned, the process is frustrating and costly. Not only do insurers have an economic incentive to deny claims, but the increasingly common use of artificial intelligence (AI) in the adjudication process also adds to the problem. For all its promise, AI doesn't have the capacity for nuance, at least not yet. This means that claims are denied based on whatever payment formula was established by the insurer, often leaving medical practices empty-handed.

The performance improvement process starts with understanding the current state of the revenue cycle. However, many medical practices don't have the capacity to review current processes and identify opportunities for improvement. Why? Denials aren't tracked correctly. Take the time to review your billing system's protocols for analyzing data about payment transactions from insurers. Payments are easy - it's the gap between the payment

(if any) and the insurance contractual amount that needs to be scrutinized.

There is a fairly good chance a denied claim should actually have been paid. The key is to focus on each line item. For example – simply concluding: “Great! We got paid $150 for that visit!” may result in leaving money on the table. Let’s say “that” visit was six services – evaluation and management, immunization (and administration fee), venipuncture, EKG, and screening. Some things you should ask yourself:

- Did you get paid for each of the six services? If not, why?
- Perhaps the administration fee was paid at $0, denied for being a bundled service. Was that determination consistent with the payer’s requirements?
- Was each line item paid correctly? If not, why?

Another example could be that all payments were reduced because of penalties associated with not complying with Quality Payment Program requirements, thereby marked as CO237 and N807. Be sure to stay informed and take some time to dig-in - the full list of denial codes can be located here.)

Identifying denials is challenging, due to the complexity of our reimbursement process. Employ the basic framework of splitting non-payments into controllable (“true” denials that could be overturned with effort by your staff) and non-controllable (contractual adjustments to which you agreed as enrolled providers that cannot be argued).

Consider these eleven denial management strategies to improve your bottom line:

1. Create a report of denials by payer, volume, and dollar; design a dashboard and request updates each month from your billing team.
2. Assign responsibility for denial management; divide between your coder(s) and biller(s) based on the reason for non-payment.
3. Prioritize efforts – don’t spend hours working on a $10 charge or the patients with their last name starting with “A;” sort the work queue by high dollars and high volume, then attack the list from there.
4. Engage your patient, as appropriate: “your insurance company has denied the authorization for this service…” Prompt them to call the Depending on the service, some patients are happy to proceed as self-pay (the insurance company may require advanced notice to the patient showing they are in agreement.)
5. Develop standard templates for appealing payers’ decisions; create a library of communications indexed by category (e.g., coding, medical necessity, registration).
6. Leverage artificial intelligence to respond to simple denials; assign the complex ones to your staff.
7. Monitor efficacy; wait 30 days after an appeal – did the payer change their decision? If not, up the ante by submitting an appeal to the payer’s medical director or other such higher-level tactic.
8. Measure and report (internally) the financial return on your efforts; include the payments received when a payer overturns a denial.

9. Dig into root causes; many denials originate in the practice – focus on *preventing* them, not just managing them.
10. Lean into the intake process: do we capture accurate information from patients? Equally, if not more importantly, how do we verify it? Turn over every rock; for example, you may find that your office-based registration works quite well, but problems lie in your inpatient consultation services.
11. Report habitual inappropriate denials to your state insurance commissioner and/or medical

If you need extra motivation to address denials, there is a higher purpose. Recognize that there are societal benefits to your efforts. If an insurance company denies a service over and over again, and we say (or do) nothing, the insurer may discontinue any payment consideration for that service in the future. This has happened many times, as we grow tired of getting denied and simply stop billing for the service. The insurer then has the upper hand, as there is no evidence that the services are even being provided. Please, if the service is eligible to be coded and billed, do it!

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