3 ways to improve your denials management efforts

Prepared by:

Desmond Hollingsworth, Manager, RSM US LLP
desmond.hollingsworth@rsmus.com, +1 404 751 9130

April 2017

U.S. hospital statistics show that 20 to 30 percent of their claims are rejected or denied on first submission. And many of those denials are not recovered during the initial billing process. Initial denials refer to denied amounts processed and communicated by insurance payers (via 835 electronic remittance advice and paper explanation of benefits). This is usually not what a health care organization writes off. Typically, the initial claim costs $5 to $7 to bill versus $25 to $30 to rework a rejected or denied claim.[1]

While these statistics are alarming, this challenge also serves as a great opportunity for health care organizations like yours to proactively manage denials instead of letting them manage you. Note the following three ways to improve your denials management efforts:

1. **Leverage your analytics, data or reports to determine your health system's unique landscape**. Understanding how to find data within your organization is a critical component of running a successful denial management program. Two important files within your organization that will help you splice and uncover the data you need are the 835 files and aged trial balance (ATB) reports. With an understanding of Microsoft Excel or Access you will be able to identify a few essential metrics to gain visibility into your facility. With this data you should be able to identify the top 10 denials, common services denied and common payers that deny claims.
2. **Establish strong front-end processes, insurance verification and eligibility checks**. As an organization, it's important to understand by payor how insurance is verified at your facility. For example, while establishing a denial management program at a large facility in the Midwest, our RSM professionals developed a payor matrix to help

pre-registration staff determine which tool to use to verify insurance based on payor. This discovery uncovered a number of broken processes within the facility: There was no systematic approach to verify patients, there were many duplicative tools and the data wasn't being stored in a way that was easy to find if a claim was denied. Your facility may not be as complex as the one noted here but it's critical to understand where and how to locate the information that you need in order to prevent denials.

Understanding the importance of insurance verification is critical to the success of a denial management program. It plays a key function in collecting data across the health system. Patient access staff members play an important role in supporting the health system financially and in maintaining patient satisfaction. Ultimately, the success of patient access staff in delivering initial services to patients as well as their knowledge in the use of insurance verification and medical necessity systems are all crucial to the success of the health system.

3. **Implement a robust claims scrubber and edit tool**. Developing checkpoints throughout the revenue cycle is an important part of proactively managing denials. Establishing and monitoring your claim scrubber is vital. SSI and ePremis are some of the most common tools used today. It's important to collaborate with your vendor to ensure your system is set up to meet the needs of your organization. You should be able to identify the top 10 edits, monitor progress on a monthly basis and create a systematic resolution path for those accounts with edits. Correcting claims that have issues before they are transmitted to the payor can save your staff time and money!

Once you've established the framework for a denials management team, the next step is to implement a strategy for these three key steps. Your health systems strategy will be based on staff, technology and the goals of the health system. Below is a kick-start diagram of how to start your denials management program.

Let's examine the scenario below to identify the magnitude of how important a strong denials management program is to the profitability of your health system.

According to the Health Financial Management Association, the average denials write-off as a percentage of gross revenue is 0.18 percent. Potentially, therefore, the following opportunity may exist for our example health system example below:

REVENUE CYCLE HEALTH CARE SYSTEM	
Gross revenue	$515,000,000.00
U.S. hospital average denial write-off rate	0.18%
Potential opportunity	**$927,000.00**
Denial write-offs as a percentage of gross revenue	

Clearly there is a sizeable opportunity to reduce denials, create front- and back-end workflows and implement technology to track denials.

Questions to consider

As part of revenue cycle claims management, denials management and payer contracts management play a pivotal role in identifying opportunities to stop revenue leakage, increase revenue and ultimately increase cash. To initiate the conversation within your health system, consider the following questions.

- What are the largest initial denial reasons by charges and by volume?
- What are the biggest payers causing initial denials by charges and by volume?
- What is your current denials management strategy?
- What technology do you use to track and monitor denials?
- What proactive steps is your organization taking to mitigate denials?

Initiating your denials management program

Assess

- Launch initiatives
- Define project governance structure
- Review denials documentation, policies, and processes
- Validate assumptions and analysis around denials management
- Conduct interviews and record observations in details management project plan
- Establish reporting mechanism with decision support to track and trend denials on a weekly and monthly basis
- Begin development of buy-in from key stakeholders and leadership
- Identify quick hits

Design

- Designate denial management project manager
- Establish a formal cross functional Denial Management Committee
- Document current state denial workflow processes
- Develop strategy and processes for implementation around denials management quick win opportunities
- Establish tracking mechanism for all aged denials
- Secure buy-in from key stakeholders and leadership on the validated opportunities

Construct

- Develop new policies, procedures, and work flows around new denial management opportunities
- Identify and develop a method to track denial overturn rates and denial loss rates
- Construct implementation strategy
- Review new policies, procedures and strategy with key stakeholders prior to implementation
- Identify necessary resources to implement identified opportunities
- Determine technology needs for denials management

Implement

- Establish go-live dates for denials management system if deemed necessary
- Deliver targeted education and process redesign to address denials at their root cause
- Implement reporting tools to quantify, track and monitor results of new denial management opportunities
- Go-live with new initiatives
- Identify and communicate process breakdowns and refine policies as needed.

Operate and review

- Continue to track and monitor new policies and denials performance
- Conduct periodic reviews of the redesigned denial management program

1 California Primary Care Association, ClaimRemedi, Inc., http://www.cpca.org/cpca/assets/File/Learning-Center/Trainings-and-Events/Billing-Mgrs-Conf/2011-05-04-Session-5-RevenueCycle-A-Neace.pdf.

+1 800 274 3978
www.rsmus.com

tl-nt-con-hc-1016