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Don't Be Denied – Denial Management

While most claims submitted to insurance companies move right through the adjustment process, some are returned for errors. The returned claims – denials – negatively impact cash flow. Take action to minimize the impact on your bottom line by reducing denials.

IN THIS ISSUE OF PULSE, WE DISCUSS IMPORTANT DENIAL MANAGEMENT STRATEGIES TO HELP

- UNDERSTAND WHY INSURANCE DENIALS OCCUR
- MONITOR REASONS FOR DENIALS IN YOUR PRACTICE
- PREVENT DENIALS BY IMPLEMENTING PROCESSES TO SUBMIT CLEAN CLAIMS
- PERFORM DENIAL DUE DILIGENCE WITHOUT DELAY

Although most of the claims you submit to insurance companies sail through the adjudication process, some are returned for errors. These returned claims – known as denials – are a problem because they signal a lack of cash flow. In short, a denial means that you don't get paid. Denials also represent additional costs to your practice because resolving them requires staff resources – sometimes, significant effort.

Understand Denials: A denial is just what it sounds like – a refusal of payment. If the amount due is transferred to the patient in the form of an unmet deductible, for example, the lack of payment isn't a denial, per se. Indeed, it should signal an immediate transfer of financial responsibility to the patient. For true denials – the insurance company neither remits payment nor asks the patient to pay – you must learn *why* the insurance company won't pay. Without this knowledge, the denial inevitably becomes a write off.

Denials can be transmitted to you in a number of formats, but the two most common are letters of correspondence explaining why the claim was denied and a code (or series of codes) next to the affected line item on the remittance advice statement the payer returns to you.

Denials by written correspondence are generally straightforward – a letter explains the reason for the denial. The more common way to learn of a denial is through Claim Adjustment Reason Codes, which are incorporated into the insurance company's remittance advice statement. In other words, payments and denials are intermixed on the same statement.

Insurance companies use alpha-numerical codes to explain their rationales for non-payment. According to Washington Publishing Company [link: http://wpc-edi.com/], which maintains the standard dictionary of codes, these Reason Codes should communicate why a claim or service line was paid differently than it was billed. Additional information about the adjustment may come in the form of Remittance Advice Remark Codes, which provide more information about the adjustment or denial. Each Remittance Advice Remark Code identifies a specific message, typically explained at the end of the remittance statement. Five common reasons for denials include:

- The procedure/revenue code is inconsistent with the patient's age.
- The diagnosis is inconsistent with the procedure.
- The authorization number is missing, invalid, or does not apply to the billed services or provider.
- Claim/service lacks information which is needed for adjudication.
- Duplicate claim/service.

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Denials…*continued*

Monitor Denials: One of the biggest challenges in your denial management strategy is gathering information. Run reports weekly that compare your claims to those paid for each payer. The time lag between submission and payment dates will vary among payers, but once the payer's average turnaround time is exceeded, it's time to investigate those "missing" claims. When a missing remittance is detected, look up the claim's status on the payer's website. If the claim is outstanding (i.e., not paid), but there is no evidence of the claim in the payer's system, resubmit the claim. If the payer's website says the claim is pended for medical review, contact their customer service center to discuss what needs to be done to get the claim paid. Often, claims pended for medical review require more documentation.

Whether they come back with individual letters or are included in a remittance advice statement, don't allow denials to go into limbo. This happens all too often. Because the denial represents a glitch in the normal process, it's only natural to set it aside to work on later after the "normal" claims have been processed. Unfortunately, these claims often end up in a pile or a drawer that someone may work on when they have time. Many practices don't even know how many denials they have waiting for action. They likely do not know how much money may be at stake.

It pays to establish a process that automatically tracks the volume and types of denials, ideally by insurance company. In order to track the data, you need to determine how to mark a denial in your practice management system. Many systems allow you to not only electronically record the denial but also include many details associated with it – the date, insurance company, balance remaining, as well as the nature of the denial. The next step is to run a report on denials, which should be done monthly. Ideally, denials can be reported based on the category: registration, coding, coordination of benefits, etc.

There are three important uses for these reports: first, to distribute work among staff; second, to identify any trends that may signal a problem needing to be fixed; and third, to monitor whether the insurance company is treating you fairly. Consider your denial management report a "treasure chest" of information to improve the performance of your revenue cycle.

Prevent Denials: Armed with detailed information about your denials, it's time to take action. Preventing denials from occurring is the best solution. Often, this involves improving the registration process – confirming insurance for each patient, for example, prevents registration-related denials. Give each area of the practice – front office, clinical team and so forth - a denials "report card." An effective method is to not only chronicle the nature of denials, but to route each denial back to its source – the person or process that caused it. Consider also tracking and reporting the time it takes the source of the denial to return the necessary information to your business office.

Work Denials: If you don't make a concerted effort to resolve denials, they won't go anywhere except into the trashcan – a write off, in other words. Fortunately, most denials can be overturned with some effort on your part. Review the reason for the denial, then do something about it before resubmitting the claim. If you merely resubmit the claim "just to see if it goes through on the second try," all you'll get is another denial, only this time it will be marked the code that indicates it is a "duplicate claim/service."

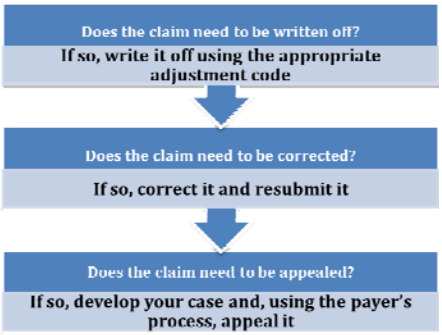
Take the time to review the specific details of each claim. If the denial was legitimate, then write off the charge. If the denial was the result of a mistake – you accidently left off the pre-authorization number your nurse had obtained, for example – correct it and resubmit the claim. If you believe that the denial was an error – that the insurance company's decision was wrong – it's time to contest the decision. It may be adequate to call, verbally explain your side of the story, and request reconsideration over the telephone. If verbal reconsideration is not an option, appeal in writing based on the process dictated by the insurance company. The company may have its own form and/or an address to which you must send correspondence regarding the denial. At this point, you are filing an "appeal" (See the Three-Step Approach to Denial Management table).

If a denial reveals, for example, that the "diagnosis code is not consistent with the procedure code," prepare and send a letter of appeal using a template from your "library" of appeal letters. Because most denials fall into a few common areas, it's not hard to build a small library of standard appeal letters so you do not have to compose each appeal letter from scratch.

Determine how effective your appeal efforts are by running reports of denials that have been appealed. Look to see if the decision regarding payment was overturned. Although the rates vary by payer, an effective denial management strategy will result in 75 percent of denials being reversed. Even if you can't reach this level, your efforts will be well worth your time because more denials will be paid.

Track all denials, preferably in your practice management system, and assign each denial a code based on the reason for the denial. Using your own set of denial codes helps you monitor the volume, dollar value and other patterns — for example, type of denial, insurance company, site of service and physician.

Denial Management Three Step Approach



Denials always represent lost money – even when they are quickly resolved, cash is affected and staff time is consumed. The best medicine for denials is prevention. Using the monthly updates of denials – your "treasure chest", focus on the reasons that come up most often. By work with clinical and administrative staff, many of the errors that cause denials can be avoided.

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