Effective denial management demands a committed team approach. Stop struggling and start building an airtight management process.

This book and CD-ROM are an invaluable combination, not just for the finance team charged with maintaining the bottom line, but for the executive team and other members of the revenue cycle team. Everyone will learn and understand what they need to do to erase bad habits, reassess the organization’s progress, and develop a process that addresses the ongoing denial management challenge.

You’ll learn how to:
- look at mistakes and understand how and why your organization made them
- find the source of denials and measure their impact
- implement successful changes to decrease future denials
- analyze your success on a higher level that strengthens your processes

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Hospitals, physician groups, home health agencies, and other provider-based groups focus increasingly on payment denials by insurance companies. Although such denials have been a problem for providers since the advent of third-party reimbursement programs, denials today have started to threaten the viability of provider organizations. Organizations aware of these issues are focusing intensely on mitigating and overturning denials, and others are only now becoming sensitive to the extent of the denial problem in their organization.

This chapter will explore denial remedies for your organization for both governmental and non-governmental payers. It will explore how you can establish a working definition of denials in your own organization, explain why providers must understand what is occurring industrywide in terms of payment denials, and suggest how denial management fits into your organization.

How will we define denials?

Defining denials
The healthcare industry does not have one universal definition of a denial. Therefore, each organization must establish its own definition. Take a minute and think about your organization’s definition of denials. What does it include? What does it exclude?
Defining denials may require you or others in your organization to reexamine the issue. This section will explore some of the possible inclusions and exclusions in the term and conclude with our definition. It will also provide a tool that you can use internally to refine your own organization’s definition of the term.

Zero-dollar payments do not equal denials
Most providers agree that if the payer’s explanation of benefits (EOB) shows a $0 payment, this claim would be classified as a denial. The EOB would represent a full denial. But what if one line on a multiple-item claim received $0 payment? Some organizations include this type of partial denial, and others do not and choose instead to focus on EOBs that are $0 overall payment.

Additionally, some organizations focus their denial efforts solely on clinical denials (i.e., those originating from the case-management department). They do not count other forms of denial as occurrences to be remedied. Doing so, however, fails to account for the larger number of administrative denials that occur within provider organizations and include failure to comply with contract terms, such as timely filing, use of correct codes, and other occurrences that result in no payment to the provider.

Account for these variations as you determine how broad your organization’s definition of denials is. Is your organization counting inpatient claims only in its definition of $0 paid, or do you include outpatient claims? For facility-based providers, it is easy to focus on inpatient claims because they are larger and easier to count. But facilities often fail to address denials that occur on the outpatient side. These denials are generally smaller in terms of dollars at an individual claim level, as is the overall dollar amount compared to inpatient denials. Despite these differences, however, many facilities have found that the occurrence of denials is higher on the outpatient side of the business (see Case study 3: Intermountain Healthcare in Chapter 8). Confirm whether your organization includes emergency room and other outpatient denials in its definition.

Also consider denials that are caused by the payer’s error or by processing delays (as well as claims that are denied as a result of the provider’s failure to perform properly) when setting your organization’s definition of denials.

Underpayments do not equal denials
Zero-dollar payments are one form of underpayment, but not all underpayments are denials. Underpayments result from a variety of causes: failure of the payer to load contracted rates correctly, delay by the payer to adjust rates for any contracted increase, and the inability of the payer to administer contract terms. However, they are unlikely to result in a zero-dollar payment.
Denials are a subset of underpayments—specifically underpayments where there is no payment. Underpayments can be extremely difficult to identify. If a service was contracted for a rate of $78 but an allowable reimbursement of $75 was made, the $3 difference reduction in fee paid would be classified as an underpayment. Some providers include underpayments in their definition of a denial. For purposes of this book we will not consider all underpayments as denials. Only those underpayments that are paid at $0 will be considered a denial.

Some organizations also consider late payments where a payment adjustment is due contractually to be part of the denial problem. These payments are less than expected (and, therefore, are a type of underpayment), but they are not a $0 denial, so even though late payment and other underpayment recovery activities may be part of the appeal process within an organization, their causes and cures are different and will not be the focus of this book.

Rejected claims
Claims sent to the payer via either electronic data interchange (EDI) or paper cannot always be entered into the payer’s claim system. Some claims may be rejected for failure to match the patient with an enrollee. Other claims may be rejected due to incomplete or improper completion of the data required in the paper or electronic claim and its associated batch. Any of these rejected claims have failed entry into the payer’s claim system; some may even have failed electronically to make it through the clearinghouse that serves the payer. These unsuccessful claims are rejected by the payer and returned to the provider as unprocessed. These rejected claims represent nonpayment by the payer unless the provider adds or changes information that allows the claim to be resubmitted and adjudicated properly.

Most provider organizations track such electronically rejected claims and trend their occurrence to identify problems in the EDI connection with the payer, coding of the EDI transaction inside the provider organization’s system, or other problems. Does your organization track EDI rejections? Are there strong processes in place to correct these edits for resubmission? Are there processes in place to track these edits and solve the problem creating their occurrence? What about paper claim rejections? Are these tracked and trended? Consider whether paper- or EDI-rejected claims are included in your organization’s denial definition.

Suspended claims
Upon receipt of electronic claims that do not make it into their system, some payers will put the claim into a suspense file that the provider can access. These claims wait for provider review. Consider whether these files are included in your definition of denied claims. Ensure that there are processes in place to review these suspended claims regularly and on a timely basis and to research any unresolved issues.
**Pended/unclean claims**

When a payer requests additional information, it will pend a claim until further response from the provider. Payers pend claims for a variety of reasons, including identification of other insurance for coordination of benefits (COB) information and review of medical records to substantiate medical need. These pended claims have not been formally denied, but without additional action by the provider, they will result in no payment activity.

Does your organization track pended claims? Do you include them in your definition of denials?

**Our denial definition**

This book will address denial management tools and best practices. The denial management process discussed here will include two key components:

1. Proactive reduction of the occurrence of denials

2. Retrospective appeal of denied claims

These components are bound by the same glue that takes denials management program to the highly successful level: effective leadership and effective management. Any instance of a provider not being paid for a service (inpatient or outpatient) will be noted and included in this book’s denial definition. As the above questions have illustrated, defining a denial is not as easy as it sounds. Thus, for purposes of this book, we will define denials as any claim line item (sometimes referred to as a service denial) that results in no payment from the payer, including rejected claims through the electronic submission process.

Without a strong management process within your organization, EDI claim rejects will continue to require rework or not be paid. We will exclude pended claims because these can be reworked and paid. We will specifically exclude underpayments from our working definition of denials, which instead will include both administrative and clinical denials (both of which result in non-payment). See Figure 1.1 on the following page for our denial definition formula.
Clarifying and communicating denial definitions

Is your facility’s definition shared by others in your organization? Use our denial definition checklist to either develop or clarify your organization’s existing denial definitions. (See Tool 10.1 in Chapter 10 for a denial definition checklist.) This list may serve as a starting point for sharing this definition throughout the organization.

To begin efforts of reducing denials, ensure that your organization has established its definition of denials. Your organization’s definition may be different from the working definition of this book, but it is a critical first step to success in managing this epidemic.

Confronting the problem

*The denial epidemic*

Consider your billing and collection process to be the circulatory system to your organization. Denials can be viewed as a clog in the arteries of the billing and collection process. Without this constant process working effectively, the organization would come to a halt due to insufficient funds.

Like clogs in the arteries, denials sometimes occur with vivid symptoms akin to those of a heart attack. Although problems with one payer may draw the everyone’s attention, denial problems, like clogged arteries, also can go unnoticed for years. If these undetected denials build up, they threaten the viability of your organization. Providers may notice they are not collecting as much income as they expect to collect but may attribute this difference to other issues and not the real cause.
If denials were a medical disease, they would be seen as an epidemic compromising the health of providers: Denial rates are reported nationally to be in the double-digit range (see Chapter 2, Measuring your denials, for several studies that support this average). This book will address the denial epidemic and what you can do in your organization. Although denials may be clear for all to see, the threat they pose for your organization’s financial health is not as easy to spot. Without a periodic health review of your organization, you cannot know for certain whether this silent killer is at work.

**Factors contributing to the growth in denials**

Healthcare payment processes have always been complex. Providers rely largely on third-party insurance for payment on most of the services provided to patients. The full extent of services required by a given patient and the associated charges for those services often are not known until after the service is provided (and sometimes not until days later). The third-party payer’s payment is not at the point of service but instead is often weeks if not months after the bill has finally been produced for these services. To increase this complexity further, the health insurance market itself is in flux.

Four factors today contribute to the growth in denials, whether from government or private payers. See Figure 1.2 below.

---

**Figure 1.2**

Factors contributing to the growth in denials

- Difficulty in confirming eligibility
- Reductions in covered benefits
- Complex contract terms
- Increasing precertification requirements
1. Reductions in covered benefits
Identifying benefit coverage has never been easy. There is no common benefit plan offering in America. Even within one payer, there is great variation from employer to employer on the services and extent of coverage offered. In general, providers are accustomed to benefit limitations in areas such as physical therapy and mental health. They have become accustomed to plans that do not cover hearing aids and other selected services, but today, plans are further limiting their coverage of key services.¹

Many states attempt to address this benefit variation by mandating coverage of certain benefits by insurers in the state. However, more and more self-insured groups are opting to offer their own plan under the Employee Retirement Income Security Act (ERISA) in an effort to be exempt from expensive state-mandated benefits. This variation adds to the complexity of determining what is a covered service under the insurance plan and what is excluded.

Compounding all of these effects, plans are adding new limits to the benefits under which they cover. In an effort to address increasing premium costs, payers are carving out from the policy a variety of services that might not be expected. These new “lite products” may carve out services like bariatric surgery, exclude preventive services, or limit the annual coverage for diagnostic services to a fixed dollar amount. These plans are growing in the marketplace and becoming increasingly popular with consumers and payers, and with increased services excluded from insurance plans, providers risk incurring more denials for lack of coverage.

2. Difficulty of confirming eligibility
Confirming that a patient is eligible for a plan is not as easy as it sounds. Through HIPAA electronic transaction requirements, we now have mandated that most payers provide automated responses to eligibility inquiries from a provider’s office. Nevertheless, few providers can support this automated query with the payer and they instead rely on labor-intensive Web site look-ups or telephonic confirmation.

Adding to the complexity of eligibility verification is the fact that eligibility confirmed today only applies to this date and to past dates of coverage; therefore, they may not be valid tomorrow when the actual service is provided. Finally, the potential for retroactive termination of insurance coverage adds to the problems encountered by providers. Eligibility confirmed for today’s services may later be updated and deemed ineligible for coverage.

Checking changes to a patient’s health insurance is now at least an annual challenge for most providers. With increasing shopping of health plans by employers, there is an increased level of
turnover in plans, which creates opportunity for denials based on lack of patient eligibility for coverage. In addition, with the high level of job turnover by employees, there is increased change in the source of insurance for each patient.

A final area of attack on eligibility is COB, in which more than one payer is responsible for the patient’s care. Payers use actual or potential COB as a reason not to pay a claim—for some payers, there may be automatic denials for COB unless the member signs a disclosure statement at the time of service to update other insurance information to the payer billed.

3. Increasing precertification requirements
Most payers today require inpatient precertification and ongoing certification of inpatient care. Health maintenance organizations (HMO) often have required precertification for some outpatient procedures. Many non-HMO plans are adding precertification to the outpatient area for services such as high-dollar radiology tests, and this trend increases the vulnerability of providers to clinical denials.

4. Complex contract terms
Despite being under contracts with most payers to ensure reasonable, timely payment, the contract terms that affect provider payments are growing increasingly complex. Issues such as timely filing, records required for payment, and appeal limitations all can affect the level of denials experienced as well as the provider’s ability to reverse them successfully. Payers increasingly reduce the window of time that providers have to submit the bill. Some payers are demanding that they receive bills within 30 days from the date of service; otherwise, they deny payment. At the same time, the window for appealing claims is decreasing. Both contract terms increase the incidence of denied payment to providers.

Provider views on denials
Denials adversely affect both the revenue and the expense sides of a provider’s financial statements. For providers of all types, denials result in a decrease to expected payments. Denials take already low contracted rates and reduce the actual payment level to the provider. They effectively lower contract yields and make already poorly performing contracts even worse. See Figure 1.3.
Denials also raise the cost of collecting patient revenue. The cost of rework associated with managing duplicate claims adds expense and no value to the provider’s bottom line. Revenue recovery activities become a new cost to the organization.

By addressing denials effectively on a proactive basis, providers can increase their revenue. Denial reduction efforts increase the net revenue line on the provider’s profit and loss statement. Denial management efforts also can accelerate cash and thus favorably affect the balance sheet.

On the expense side, proactive denial management efforts can raise productivity through process improvement. They also can decrease rework, thereby further decreasing operating expenses.

**Payer views on denials**

Unlike the John Grisham novel The Rainmaker, in which the insurer Great Benefits operates on a business model to deny all claims within three days, insurance companies do not set goals for denying claims. In fact, most payers will acknowledge that medical management denials are a failure of the medical management process in which parties could not agree on the level of care. Payers do, however, acknowledge a variety of problems that result in unintended clinical and administrative denials, which can result from both internal payer operational problems and from provider-generated issues.
Following are three common problematic areas for payers that result in denials:

1. **Authorization not found**
   Although providers may have obtained an authorization for services, the payer may not find the authorization at the time of processing the claim. This situation will result in a denial for the provider and can occur for a variety of reasons, including lags in entering the referrals into the claim system by the case management staff at the plan or inability to exactly match the provided service with the authorized service.

   In an HMO setting, this type of denial can occur with newborns when the specialty referral sits in the mother’s record because the newborn has not been established as a separate subscriber. By the time the provider of the specialty referral bills out services, there is a separate subscriber number for the baby. But the baby’s referral has never been moved to the new subscriber account, which results in the service being rejected as referral not found.

2. **Eligibility terminations**
   Payment decisions begin with determining whether the subscriber is active with the insurance plan. Indeed, termination of coverage is problematic for all in healthcare. Health plans do not get instantaneous information from employers or subscribers, and this lag alone can result in provision of incorrect eligibility advice. Compounded by the negligible amount of real-time eligibility connection between providers and payers, the delay between time of verification to time of service delivery can result in services being provided to patients who no longer qualify for benefits.

   Retroactive terminations of eligibility add to the challenge of determining coverage. Payers generally allow an employer up to 90 days to report employee benefit changes, such as retirement, severance, change from family to single coverage, etc. Therefore, this change in eligibility can occur long after the provider has preauthorized and delivered services. In fact, the change can occur even after initial payment has been made to the provider. Adjustments in eligibility result in denied claims.

3. **Duplicate claims**
   Currently, insurers do not support real-time claim payment to providers. As in credit card processing for payment of retail services, there is a lag between the time of claim submission by the provider and payment adjudication and check release by the payer.

   If you add to this timeline the lag time providers take to post payments into their billing system, it is easy to see how months go by between the time of billing to posting of payment. During that
time, providers often rebill services to ensure claim receipt by the payer. Duplicate claims are created, resulting in denial of the second claim.

Internal operations at the payer also may contribute to duplicate claims in which payers pend certain claims for review. Pends increase the handling time of a claim and reduce the likelihood that it will be paid before the provider rebills services the following month. Pended claims add to these rebills that are denied as duplicate claims, which increases the handling cost for both payers and providers on such slow-pay claims.

Who is responsible for denials?

Taking the holistic approach

Where does responsibility for the denial function rest in your organization? That is, which one person or area manages it? We will explore how this function can and should exist in your organization.

Denial management is often seen as a function owned by one person or department within the organization. For example, denial management may reside in case management. It may be added as additional responsibilities for the collection staff to pursue in their free time, or there may be a central recovery unit specifically focused on collecting denials, underpayments, and late payments from payers.

To cure denials, we must look at the denial problem holistically and not as an isolated event to be fixed by one area. As we will explore in Chapter 3, multiple entities in the organization contribute to the occurrence of denials and therefore have a role in reducing denials throughout the enterprise. Denial management is more than one person or one department.

The issues that cause and can cure denials are located throughout the organization, and they generally reside in the revenue cycle. Everyone affecting the revenue cycle has a role in managing denials. Figure 1.4 illustrates the revenue cycle.

With each functional area, such as nursing charge entry, we have illustrated one area in which denials may originate as a result of work performed in this area. In this example, if nursing is late in entering charges, charges may not be billed out in time to meet the filing deadline imposed by the payer. This situation would result in a denial for untimely filing. Thus, each area of the revenue cycle has the opportunity to both cause and cure denials.
Whether your organization has a centralized revenue recovery unit or a single staff member assigned in the patient finance area to appeal denials, denial management is not the job of a single department or person. To be effective, reducing denials is the job of everyone in the organization, from the executive suite to the staff delivering patient care. To have patient finance or case management focus on the role alone will make your efforts to reduce denials less effective.

**Employ executive sponsorship to speed the process and cut red tape**

To be effective in your denial processes, your organization will need to retool procedures to reduce the occurrence of denials, add or enhance recovery processes, and consider resource redeployment, such as staff and technology.

We will discuss best practices and new approaches throughout the remaining chapters of this book. Executive leadership continuing commitment to this effort is a hallmark of superior...
performing organizations. These organizations recognize that denial management is not a one-time project but rather an ongoing focus of the enterprise to ensure its financial health.

In addition to defining responsibility, high-performing organizations have an executive sponsor who champions the effort. This is especially important in larger provider organizations, whether physician groups or facilities. The executive responsible for the denial efforts is able to cut across departmental lines that fragment effective management of the revenue cycle. Clinical and financial staff are accountable to this person for reducing the occurrence of denials in the organization. In a critical function, the executive integrates the disparate parts of the organization to ensure that denials are not just effectively appealed when they occur but also that the overall incidence of denials within the organization is reduced long term.

Case study 1: Children’s National Medical Center in Washington in Chapter 8 features executive sponsorship of their denial efforts has produced extraordinary results that have been sustained in a dynamic environment.

**What will you get from this book?**

**Goals**

The goal of this book is to offer tools and practices to manage denials effectively. Our aim is to offer something for both those providers just starting and to those providers that have been addressing denials for some time. This book contains ideas that can be revisited as your processes improve. Periodically referencing the book and its ideas can help you reassess your ongoing denial management efforts.

For those groups with current successful denial efforts in place, we aim to provide new approaches that may not have been considered yet. We also hope to challenge those already committed to denial management to think about issues from a different vantage point. This may mean considering initiatives that were previously tested and proved unsuccessful, and it may include considering other approaches that may improve the outcome.

High-performing organizations should read this book with the following questions in mind:

- How certain are we that our organization does not have some of these issues? What tests have we conducted recently to ensure that new or different issues are not occurring and adding to our denial problems?
• For efforts we have tried and not continued, is there a way to modify these ideas to make them successful today for our organization?

• Based on the ideas in this book, can we generate an option that is different than those presented and that would be even more effective for our organization?

For those organizations just starting out in denial management, we will provide an in-depth understanding of the areas that affect denial occurrence and successful approaches to mitigating them. There also will be a wealth of tools and checklists to jump-start your denial efforts. Consider using this book to educate your executive team or other departments on the complexity of the denial management effort.

Questions to consider as you use the resources in this book include the following:

• With whom do I need to share this information within my organization?

• What questions do I have about the occurrence of denials or their resolution in my organization?

• Which tools or recommendations could we immediately adopt to get started?

Moving forward
The rest of this book will take you through the denial management process. We will begin by looking at measuring denials. Establishing a baseline measure of denials is an effective first step for organizations just starting in the denial management arena. Estimating the impact of denials focuses the organization’s attention on the magnitude of the dollars being lost.

For those organizations with existing denial programs, we will address how to test the validity of your internal measures periodically. We will provide several industry benchmarks against which you can assess your data capture. Finally, we will explore how to improve the usefulness of your most critical denial measurement tool, the denial-tracking database. We will identify a variety of variables to consider including and exploring questions that should be posed in using this critical resource.

Endnotes

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