DENIALS MANAGEMENT
BEST PRACTICES:
IDENTIFYING THE LOWEST HANGING FRUIT

By A.J. Johnson, General Manager of Analytic Solutions, TriZetto Provider Solutions™
THE GROWING IMPORTANCE OF DENIALS MANAGEMENT IN THE NEW ERA OF HEALTHCARE

How much time does it take your organization to manage claim denials? It’s probably much more than you would like to spend.

However, of all the efforts you put toward ensuring your organization is financially successful, managing denials may be the most critical step – especially when you consider that providers transmit millions of claims every day and even the best-performing medical practices experience a denial rate of five percent.² Having a strong denials management process can help you recoup significant revenue that would otherwise be lost, as well as identify trends in errors, so you can correct your processes to prevent future denials.

This e-book reviews why denials management has become more important in the new era of health care. It also provides tips on how to identify denials that represent your “lowest hanging fruit” so you can focus your efforts on appeals that will have the most financial impact.
Today’s financially challenging environment

In today’s healthcare environment, it is challenging for providers to succeed financially. Here are some of the top issues impacting your revenue.

1. Healthcare costs for providers continue to rise. One of the top five challenges facing medical practice business leaders is dealing with rising operating costs. There have been exciting advancements in medical technology and equipment that can bring long-term cost efficiencies for providers, but they require large investments upfront. These expenditures, combined with costs associated with electronic health record implementation, have put many providers in a financial crunch.

2. Reimbursement rates are declining. Providers have faced repeated cuts to Medicare and Medicaid reimbursement over the past several years. In addition, the Affordable Care Act has impacted reimbursement for providers in the form of value-based payment models and cuts in the Disproportionate Share Hospital payment program to reimburse hospitals for caring for the uninsured.

3. It’s harder to get paid. In today’s healthcare insurance market, high deductibles prevail and healthcare savings accounts are common. What does this mean for providers? According to revenue cycle management expert Elizabeth Woodcock, 30 percent of a medical practice’s revenue comes directly from patient responsibilities and that is expected to grow. Almost six out of seven (85 percent) employers have implemented an increase in medical plan employee cost sharing or are considering doing so through plan design changes over the next three years.

This increase in patient responsibility is challenging because patient payments are the hardest revenue to collect. Fifty-five percent of patient payment responsibility after insurance ends up as bad debt.

To offset these financial challenges, you need to ensure you are getting paid correctly from payers. A big part of that is identifying, appealing, and tracking claims that were denied incorrectly. This potential revenue loss isn’t easy to see when it’s hidden. If left unchecked, denied claims can significantly impact your bottom line.

Only one out of three providers (35 percent) appeal denied claims. And, even today, many of those providers still use a highly manual and heavily paper-oriented approach to managing denials. Here’s a summary of what this process typically looks like:

Step 1: A cash flow representative goes through a stack of remittances received from payers.

Step 2: When they see a denial was made, they put it into a separate pile.

Step 3: This pile is passed along to a second representative who focuses on denials.

Step 4: That denials representative manually logs the remittance information, including date received, type of denial, amount of claim, insurer, remark code, and payer appeal deadline, into a spreadsheet so they have a record of the denials.

Step 5: The denials representative researches the insurer’s requirements for resubmitting denied claims.

Step 6: The denials representative begins work on the manual appeal process, which could include filling out a specific payer form, preparing a letter to describe your case for reconsideration, or compiling documentation of the service and a record of the original filing of the claim. The tedious process of appealing denials to get them overturned costs nearly $15 per claim, according to the Medical Group Management Association. And, all of this work needs to be completed before the payer’s appeal deadline.

While providers may have some level of technology to help automate aspects of this process, many of them are not using the technology to its fullest extent because it’s not integrated into their workflow and, therefore, not easy to use. Or, their technology doesn’t help with the most important aspect of denials management, which is aggregating data in an organized way so you can easily uncover trends and analyze the root cause of your denial issues.
A BETTER WAY TO MANAGE DENIALS

A manual denials management process is time intensive. To make sure the time you invest is worthwhile, you should focus on denials that represent the “lowest hanging fruit.” Here are three ways to identify denials that will yield the highest return when appealed.

1. Fastest payment opportunity
   Review your historical claims and remit data to track when you received denials and when you received the correct payment back from the payer. By measuring this, you can determine what types of denial reason codes have the shortest appeal resolution time to help you get money in the door faster.

2. Highest value denial
   When you receive denials, look at your historical data to determine and track how much you typically get paid for the type of services provided on the claim. Focus on appealing claims that bring in the highest amount of revenue.

3. Highest probability of getting paid
   Focus on denials that you can most easily fix, such as those where information was missing from a field or where coding or data was incorrect due to human error. You can easily fix this information and resubmit the claim. Other denials may be out of your control, such as denials due to a service that was never documented or benefit eligibility issues. You won’t be able to convince the payer to pay for undocumented services or change their fee schedule contract, so these denials are not worth your time to appeal. However, to help stop this type of denial from occurring in the future, you should go back and review your eligibility verification process to ensure it is working correctly.

Focus on these three areas to identify where you’ll receive a high return on your staff time investment for appeals.

CONCLUSION

Denied claims represent unpaid services and revenue that you deserve. On the surface, the work that goes into identifying, tracking, and appealing denials may seem too time intensive. However, the number of denials you receive and the missing revenue they represent can add up quickly. The denials management process can be made much more efficient if you know where to focus your efforts. Now’s the time to take a closer look at your denials management process to identify which denials represent your “low-hanging fruit” so you can spend your time on appeals wisely.
HOW TRIZETTO PROVIDER SOLUTIONS CAN HELP

Smart healthcare providers know that successful billing and payment processes are vital to a healthy bottom line. That’s why they count on TriZetto Provider Solutions. Our smart revenue management solutions not only help you get paid quickly and accurately, but they also enable you to understand what’s really going on with your payments.

Assessment call
Take a five-minute break to see how our denials management solutions compare to your current tools.
REQUEST A CALL

Check out our denials management solutions

Electronic patient eligibility verification
Delivers fast and accurate electronic insurance verification, providing a cost-effective way to reduce one of the most common reasons for denials: incorrect patient eligibility data.
Learn More...

Denials analysis report
Automatically tracks and organizes denials into 24 high-level categories so you can quickly identify trends to fix ongoing problems that cause denials.
Learn More...

Advanced reimbursement manager™
Provides powerful analytic reports that quickly identify areas where you can recoup lost revenue from both underpaid and denied claims, including “low-hanging fruit” denials with the highest probability of getting paid, highest revenue opportunity, and fastest expected turnaround time. The typical recovery is more than $300 per provider per month. Also automates the appeal process, cutting appeal costs down to less than $1 per claim.
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References

About the Author
A.J. Johnson brings more than 26 years of experience in managed care provider and payer network contracting, claims billing, and sales and marketing. A.J. began his career in health care administration in 1986. Over the next 13 years, he managed all aspects of network development, including hospital, ancillary, physician, and provider relations. Later A.J. integrated PPO networks nationally and managed worker’s compensation provider networks.

In the provider space, A.J. has held high-level positions with the startup company that would later become NHXS. He returned to TriZetto Provider Solutions, formerly NHXS, in 2006 as director of operations and was recently promoted to general manager of analytics solutions.