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six steps to an effective denials management program

Yes, it used to be just a nuisance. But denials management has become a high priority for savvy healthcare CFOs.

AT A GLANCE

The following six steps can help you manage denials management issues in your organization:

- > Create standard definitions of denial types.
- > Establish a denial hierarchy.
- > Establish a centralized denial database.
- > Develop key performance indicators.
- > Build responsibility matrices.
- > Measure, monitor, and take action.

Denials management has become one of the most hotly debated and pervasive topics in health care. In the past, it was more of a nuisance issue for CFOs. Today, denials management aggressively competes among CFOs' highest priorities and is also on the radar screen of many CEOs. Providers are dedicating substantial resources to denials management in the form of denials steering committees, revenue recovery teams, dedicated specialist FTEs, and, in some cases, entire departments wholly devoted to denials management. The challenges facing healthcare decision makers are determining which denials management strategies are effective and finding ways to put them to work.

Just how important is denials management to your bottom line? In a 2004 survey of healthcare CEOs conducted by the American College of Healthcare Executives, seven out of 10 respondents identified "financial challenges" as their top concern, and half of that group attributed "revenue cycle and denials management" as one of their top five financial challenges. Other studies have suggested that implementing an effective denials management program can have a more dramatic impact on improving the bottom line than any other single revenue-generation or cost-reduction initiative. The consensus is that an effective denials management strategy is crucial to minimizing a healthcare provider's revenue exposure.

Step 1: Create Standard Definitions of Denial Types

Before any management problem can be solved, it must first be defined. This holds especially true for denials, which enter the provider's doors in a variety of shapes and sizes.

FEATURE STORY

Managers in provider organizations tend to define denials based on how their areas of responsibility are affected. For example, to a case manager, denials often relate to issues of medical necessity. To patient financial services leadership, denials can be more about “being nicked and dined to death” by payers within the claims adjudication cycle. To the CFO, a denial might be anything that results in a loss of revenue on a per-case basis, including underpayments. To further complicate the issue, additional outside factors contribute to “denial creep,” such as a lack of industry standardization and best practices; inadequate IT tools; and myriad revisions in regulatory and claims submission requirements from the Centers for Medicare and Medicaid Services, fiscal intermediaries, and third-party payers.

The first goal should be to create standard denial definitions. Once defined, denials can be dealt with in the way that is most effective for their type. Very generally, a denial can be defined as “a lack of *expected* payment from a payer.” It could consist of an interim or temporary delay in payment or a complete refusal to pay either the entire claim amount and/or specified line(s) of a claim.

There are two basic types of denials: *soft* and *hard*. Denials can be further clarified by understanding their functional origin. For example, a denial in which an ICD-9 diagnosis code is missing or invalid will likely best be resolved through the medical records or health information management department. The ability to precisely define denials (for example, “soft clinical, medical necessity”) leads to developing action that is most effective for that denial type.

Denial definitions are also effective in quantifying denials management success. For example, setting up a framework that effectively tracks and measures the win/loss ratio of denials (overturn analysis) is important in understanding how to properly focus internal resources for both short- and long-term success.

Soft denial. A soft denial is a temporary or interim denial that has the potential to be paid if the provider takes the right follow-up actions. Soft denials are often thought of as “controllable” or “preventable” denials. For example, a payer may temporarily deny a claim because required information such as attending physician, diagnosis code, or insured’s identification is missing. If the provider subsequently submits the required information, the payer will, in most cases, remit payment.

Studies have suggested that an effective denials management program can have a more dramatic impact on the bottom line than any other single revenue-generation or cost-reduction initiative.

Hard denial. A hard denial is often considered by the provider to be lost or written-off revenue. Providers often track lost denials on their information systems using transaction write-off codes. In the example above, if the provider failed to provide the additional required information and then missed the timely filing date, the account might be written off to “Txn Code 123—Denied Timely Filing.”

In addition to these two basic types, denials can be further broken down into functional categories such as clinical, technical, or short pay (otherwise known as underpayments), or defined with specific root-cause descriptions.

Clinical denial. In a clinical denial, the payer disputes medical necessity, length of stay, or level of care. Payers use acuity-of-illness or intensity-of-service criteria to make their determinations. Clinical denials can be concurrent (while the patient is still in-house) or retrospective (after the patient is discharged), and typically begin as soft denials. If the provider is successful in appealing or overturning the dispute, a hard denial or write-off is avoided.

An effective denials management strategy is crucial to minimizing a healthcare provider's revenue exposure.

Technical/administrative denial. A technical or administrative denial is one in which the payer has notified the provider by means of the remittance advice process with specific information describing why a claim is denied. This is typically done through remark and/or explanation-of-benefits reason codes.

Short pay denial. A short pay denial, also referred to as an underpayment denial, is issued when the payer incorrectly pays a claim. Typical underpayment denials include invalid per diem, invalid case rate applied, claim paid at diagnosis-related group rates (stop-loss applies), and claim paid at per diem rates in error.

Step 2: Establish Denial Hierarchy and Business Logic Crosswalks

Once core denial categories have been established, the next step is to develop a hierarchical

framework that properly organizes both the nature and type of denial. Like building a house, the most important part of the process is the design, planning, and requirements phase. The blueprints often reveal when something is off or missing. As shown in the exhibit at the bottom of this page, denial hierarchy is defined from the top down, starting with the root definition. Note that the underlying topology of key functional areas and root cause is “mirrored” between soft and hard denials, thus enabling a framework for conducting retrospective denial overturn analysis.

Once the denial hierarchy has been established, the next step is to map or “crosswalk” the various root-cause denial reason codes to their appropriate functional areas, as shown in the table at the top of the next page.

Step 3: Establish a Centralized Denial Database

A centralized denial database is a consolidated repository of all enterprise denial data, optimized for reporting and analysis. Storing, organizing, and analyzing these data can provide crucial intelligence about averting future denials.

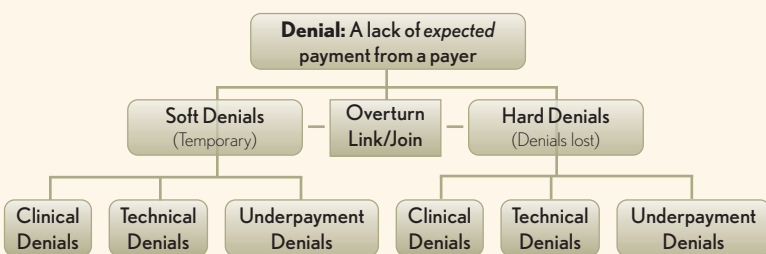
In cases of medical necessity disputes or clinical denials, if the patient is still in-house, a payer may deny hospital days during the concurrent review process. If the patient has been discharged, a letter of denial may arrive shortly thereafter, indicating that the patient's stay exceeded the authorized days. Both examples generate data points that should be properly stored in a database.

EXPLANATION-OF-BENEFIT REASON CODES

EOB Codes	EOB Descriptions
15	Claim/service denied because the submitted authorization number is missing, invalid, or does not apply.
16	Claim/service lacks information needed for adjudication.
17	Claim/service denied because requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	Claim denied; this is a work-related injury/illness and thus the liability of the workers' comp carrier.
20	Claim denied; this injury/illness is covered by the liability carrier.
21	Claim denied; this injury/illness is the liability of the no-fault carrier.
22	Claim denied/reduced; care may be covered by another payer per coordination of benefits.
23	Claim denied/reduced; charges have been paid by another payer as part of coordination of benefits.

Source: ANSI X12 835 CASEOB Remark Codes.

EXAMPLE OF DENIAL HIERARCHY



FEATURE STORY

SAMPLE DENIAL HIERARCHY WITH ROOT CAUSE TO FUNCTIONAL AREA CROSSWALK						
Root Definition	Denial: A lack of expected payment from a payer					
Tactical Definition	Soft Denials (Temporary)			Hard Denials (Write-Offs)		
Functional Definition	Clinical Denials	Technical Denials	Short Pay Denials	Clinical Denials	Technical Denials	Short Pay Denials
Root Cause	<ul style="list-style-type: none"> > Medical necessity > Noncovered services > Level of care > Nonemergent > Etc. 	<ul style="list-style-type: none"> > Eligibility > Coordination of benefits > Diagnosis invalid > Duplicate claims > Invalid/missing information > Timely filing > Etc. 	<ul style="list-style-type: none"> > Per diem > Case rate > Stop loss > Fee schedule > Percentage changes > Etc. 	<ul style="list-style-type: none"> > Medical necessity > Noncovered services > Level of care > Nonemergent > Etc. 	<ul style="list-style-type: none"> > Eligibility > Coordination of benefits > Diagnosis invalid > Duplicate claims > Invalid/missing information > Timely filing > Etc. 	<ul style="list-style-type: none"> > Per diem > Case rate > Stop loss > Fee schedule > Percentage changes > Etc.

Many case management departments keep detailed logs of this information in the form of Excel spreadsheets. Although this policy can meet the objective of resolving active cases on a one-by-one basis, the information also should be stored in a more robust centralized database to allow for retrospective analysis. Technical denials often arrive through the payer remittance advice process in either electronic or paper form, and underpayments are often revealed through a combination of the output from a contract management system, or proration logic from the health information systems platform as well as remittance advices.

Although organizing all these data into a single centralized database may seem daunting, advances in data consolidation solutions should make the process less painful than in the past, and the value of the intelligence created should more than justify the effort. Preparation is crucial; the creation of standard denial definitions undertaken in step 1 will make the design and building phase of the centralized denial database far easier.

The choice of tools and software is also important. Be cautious about using small-business tools such as Excel and Microsoft Access as primary applications for managing the denials database. Depending on the size of the organization, these solutions may not prove sufficiently scalable in the long term.

The middle table lists the primary data sources for each broad denial category.

KEY DATA SOURCES BY TYPE OF DENIAL

Type of Denial	Key Data Sources
Clinical Denials	<ul style="list-style-type: none"> > Appeal letters > Case management logs (concurrent and retrospective review) > Payer remittance advices (electronic and paper)
Technical/Administrative Denials	<ul style="list-style-type: none"> > Electronic remittance advice (ANSI 835 v4010 and other unique electronic payer formats) – denial reason codes are contained in both remark codes and adjustment reason codes segments of the ANSI 835 > Paper remittance advice (often free-text denials that need to be crosswalked to a key reason code list)
Underpayments	<ul style="list-style-type: none"> > Output from contract management software that models expected payment > Output from health information systems proration module that models expected payment > Payer remittance advices (electronic and paper)

SAMPLE DENIAL KEY PERFORMANCE INDICATORS

Overall denials rate as a percentage of gross revenue: ≤ 4 percent
 Clinical denials rate as a percentage of gross revenue: ≤ 5 percent
 Technical denials rate as a percentage of gross revenue: ≤ 3 percent
 Rate of additional collection for underpayments: ≥ 75 percent
 Rate of appeals overturned: 40 percent to 60 percent
 Electronic eligibility rate: ≥ 75 percent
 Physician precertification double-check rate: 100 percent
 Case managers' time spent securing authorizations rate: ≤ 20 percent
 Percent of high-revenue managed care contracts modeled (80/20 rule): 100 percent
 Total denials reason codes: ≤ 25

Source: *Self-Assessment Tool: Billing Follow-Up*, Healthcare Financial Management Association, 2004
www.hfma.org/resource/focus_areas/patient_financial_svcs/400290.htm

Step 4: Develop Key Performance Indicators

Key performance indicators are quantifiable, predefined measurements that reflect the critical success factors of an organization in dealing with denials. They enable decision makers to better

important to collect root cause data on denials at the functional and employee level, and routinely communicate results to department managers. A responsibility matrix is an excellent tool for providing department-specific detail and assigning accountability at the functional level.

The ability to precisely define denials leads to developing action that is most effective for that denial type.

understand business functions such as metrics deviations, trending, ranking, variance, dependency analysis, and business segmentation. KPIs that are carefully thought out create a vehicle for rapid insight into where problems and/or opportunities exist.

The list on page 85 provides examples of how to structure KPIs for denials management effectiveness.

Step 5: Build Responsibility Matrices by Functional Area and Employee

To help in the evaluation of denial rates and the timely identification of areas of opportunity, it is

The matrix should include such information as the clinical root cause of the denial (for example, “not a covered service,” “not medically necessary,” and “not a medical emergency”); the number of accounts denied for each root cause; the amount of denied accounts receivable outstanding; the accounts and A/R outstanding as a percentage of the whole; and the name of the employee responsible.

Step 6: Measure, Monitor, and Take Action

By successfully following steps 1 through 5, organizations can establish a denials management platform that enables stakeholders to measure, monitor, and take action. The goal is to develop relevant and actionable denial intelligence to answer questions such as:

- > How many denials have we had this quarter? How many were clinical versus technical?
- > What has been our overturn experience for medical necessity denials?
- > What claims (technical denials) were denied yesterday, and why?

TECHNICAL DENIALS BY FUNCTIONAL AREA						
Top 5 Active/Open Cases						
Rank sort by: Dollars denied Post date: May 17, 2005						
Rank	Functional Department	EOB Remark Code	Description	No. of Denials	Dollars Denied	Percentage of Total Denied Dollars
1	Patient Access	1	The recipient is not eligible for services on the date(s) of service billed.	867	\$788,970	27.7
2	Patient Financial Services	10	This service is a duplicate of a previously paid claim.	377	\$659,750	23.2
3	Patient Access	243	The authorization submitted on the claim is unknown or invalid.	175	\$595,000	20.9
4	Case Management	6	The date of service(s) reported on the claim exceeds the number approved on the authorization.	82	\$401,800	14.1
5	HIM/Medical Records	18	The diagnosis provided is either missing or invalid.	441	\$401,751	14.1
				1,942	\$2,847,271	100

TECHNICAL DENIALS BY REVENUE CYCLE AREA					
Post date: May 17, 2005					
Please select which departments you wish to evaluate.					
Functional Department	<input checked="" type="checkbox"/>	No. of Denials	Percentage of Total Denials	Dollars at Risk	Percentage of Dollars at Risk
Access Management	<input checked="" type="checkbox"/>	1,763	39.9	\$1,584,937	28.3
Insurance Verification	<input type="checkbox"/>	52	1.2	\$624,587	11.2
Medical Records/HIM	<input checked="" type="checkbox"/>	777	17.6	\$1,425,018	25.5
PFS Billing	<input checked="" type="checkbox"/>	1,178	26.7	\$1,113,210	19.9
PFS Follow-up	<input type="checkbox"/>	567	12.8	\$511,995	9.2
Payer Contracting	<input type="checkbox"/>	78	1.8	\$332,198	5.9
		4,415	100	\$5,591,945	100
Please indicate the top ____ root-cause reason codes per department.					

- > What are the top five technical denials across our major payers?
- > Of all the denials, where should we focus our resources?
- > What is the root cause for high-value denials? Most frequent denials?
- > What are the denial and net revenue trends by department, payer, or service?

An example of a ripe opportunity could include defining the top five EOB reason codes (in dollars) that resulted in denied claims, as shown in the table on page 86.

Another example might be to identify the top three denial codes by functional department, as well as the associated denied dollars in those areas, as shown above.

Summary

The administration of preventable denials, rejections, and recoverable revenues is one of the key survival challenges facing most hospital CFOs and CEOs today. Healthcare organizations can begin to improve profitability immediately by implementing an effective denials management

program that works toward bridging the semantic gulf of denial definitions, creating denial hierarchy maps and crosswalk frameworks for assigning accountability and follow-up, and evaluating the evolving nature of denials on an ongoing basis through database analysis. By implementing an effective denials management program, provider organizations can reduce revenue exposure and thus maximize financial performance and profitability. ●

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