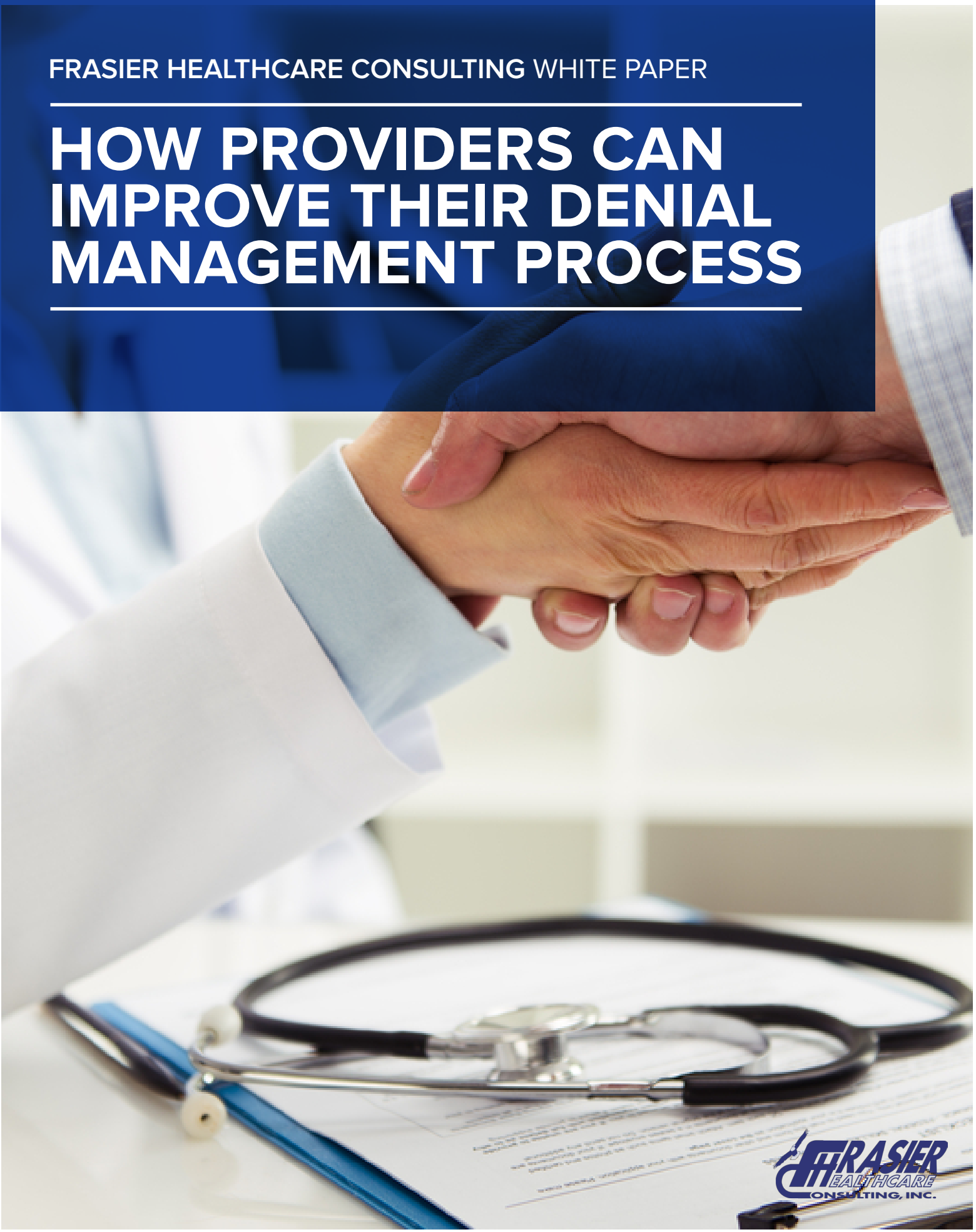
FRASIER HEALTHCARE CONSULTING WHITE PAPER

HOW PROVIDERS CAN IMPROVE THEIR DENIAL MANAGEMENT PROCESS



INTRODUCTION

Providers consistently struggle to offer quality health care and turn a profit because payers often deny claims. ***In fact, the Government Accountability Office reported that denial rates range between 11 and 24 percent, depending on the state.*** *And there aren't many states that even track this information, so the number could be higher.*

Oft-denied claims aren't the provider's fault. Denials are a frequent headache in the health care industry and happen for a variety of reasons including uncovered charges, document mistakes and missing information and the usage of an out-of-network provider. These roadblocks prevent providers from being paid on time, if at all.

It's critical that health care providers understand how denials affect their bottom lines, why they need to solve these predicaments and how to reduce denials. Daren Bush, director of patient financial services at Knox Community Hospital, noted that years ago providers may have thought they could fix the problem after the claim was denied. However, that's no longer an option. "The culture has always been, 'They'll fix it on the back-end.' Those days are gone," noted Daren Bush, director of patient financial services at Knox Community Hospital, according to Healthcare Finance.

"It's imperative we start at the time of the first patient encounter, which is pre-registration, to ensure the patient information is correct and valid. You can't be effective on the back-end without technology to ensure data quality on the front-end."

While decreasing claim denials can be a tricky process, it's not impossible for providers to overcome.

"When a claim is denied, consumers should not view that as the end of the story," explained

Katherine Vukadin, an assistant professor at Texas Southern University's Thurgood Marshall School of Law in Houston, according to Bankrate.

And while Vukadin may have been talking about customers - as in patients – her statement also holds true for providers. Providers can take steps to improve their bottom lines, but instead of reacting to denied claims, we suggest getting out in front of the problem to ensure that claims aren't revoked in the first place.

And they should take these steps sooner rather than later.

"I fully expect denial rates to go up. The question is, will they blow up when they go up? Will it be so much that you're not prepared to handle it?" *Joshua Berman, director of ICD-10 at RelayHealth Financial, said to RevCycleIntelligence.com.*

Providers simply can't wait any longer – they need to adjust how their practice operates so they can reduce claim denials before they damage their companies beyond repair. Berman went on to note that he and many others are "finding solutions ahead of time" instead of waiting for the problems to come to them.

DENIALS – WHAT WE KNOW AND WHAT WE SHOULD KNOW

Each year insurance companies deny millions of claims, causing patients to pay more out of pocket for services, not receive critical treatments on time or worse, not obtain services and medication at all.

Claim denials happen for a variety of reasons including missing claim information, lack of claim specificity, late submissions, in-and-out-of-network provider confusion, authorization issues and treatment-specific problems such as those related to radiology same-day authorization.

In the event of the latter, most insurance plans require patients to obtain pre authorization for PET, MRI and CT imaging. This appears like it should be an easy process - and in most cases it is. However, problems arise when communication breaks down between providers, insurance companies, and patients and their physicians. For example, did you know some insurance companies actually use third-party specialists for their

preauthorization procedures? Because insurance companies sometimes secretly play the role of an intermediary, they may accidently provide incorrect information to clients, telling providers that patients don't need authorization when they do. Imagine the surprise when a patient has to pay hundreds or thousands of dollars out of pocket for a CT scan because his or her claim was denied for not having the proper authorization. (Often, providers divulged this vital information upfront, but we're talking about worst case scenarios after all.)

To solve authorization issues, providers must be proactive. They should work with insurance firms to examine policy procedures and preauthorization requirements.

Building a simple list (that needs to be updated over time) is an easy process that improves accuracy. Providers can roll this list out to their employees, and from there health professionals can keep patients better informed about preauthorization regulations prior to service.

Obtaining accurate information also goes beyond insurance companies. For example, some providers submit false claims about the procedure or fail to provide enough information. This delays the process, if not outright cancels it, if a patient either can't pay for the service out of pocket or his or her deductible is too high.

Timely and accurate processing of denials is critical to a provider's success.

KEY STRATEGIES, STEPS AND TACTICS IN A SUCCESSFUL DENIALS PROGRAM

Communication is the key to solving claim denials. However, it's better to proactively communicate problems and solutions than to abruptly react to them - or worse, not do anything at all.

While we understand some claims denials are out of the provider's hands, a good portion of claim denials can be solved by establishing a Denials Dollars Task Force of revenue-cycle leaders and stakeholders - including but not limited to accounts receivable management, health information management, case management and other high-revenue volume service departments.

This task force could have the critical role of accomplishing at least the following:

- Determine how effective internal and external processes and controls are for preventing claim denials.
- Evaluate the processes for denials resolutions. Interview staff involved in helping patients whose claims have been denied, to determine if denials are being defined and tracked.
- Assess the denial process to determine if management is following industry best practices.
- Perform related "root-cause" analysis.
- Analyze write-offs due to untimely appeal and follow-up.
- Establish company regulations to better service patients - such as correcting all denials within five days and instituting goals such as reducing denial rates to less than 2 percent.
- Identify and quantify resources to minimize future "root-cause" denials.
- Develop a standard workflow for denial types, and classify denials by reason, source, cause and other distinguishing factors.
- Hold monthly financial roundtables with management to discuss areas of particular importance such as specialty-specific denials in surgery, transplants and radiology. This information should all be recorded.

BENEFITS TO BE REALIZED

Reducing benefit claim denials must be a top priority for every provider. Doing so will help accelerate receivables, reduce point-of-service collection issues and reduce aged receivable reports.

It doesn't matter how big or small providers are, or what kind of technology they're using to treat patients or even collect bills. They're often at the mercy of patients who either can or can't balance their accounts.

For providers to help themselves, they need to help patients by ensuring they understand all aspects of their procedure and service upfront. Providing a 360-degree view improves workflow efficiencies including limiting claim reduction and reducing any partner (vendor) fees.

For help in this matter, providers may want to consider working with a third-party consultant. These professionals can examine entire departments and help them manage and improve the efficiency of their revenue cycle process.