Don’t be Derailed by Denials

7 Strategies to Slash Your Denial Rate

UNDENIABLE CHALLENGES
INTRODUCTION

Denial management in healthcare continues to be a challenge—in part because the traditional way of working denials is time-consuming, costly, and prone to error. Denials eat up as much as 3-5% of provider revenue, and according to some projections denial rates trend as high as 20%.

In healthcare today, the goal isn’t just making denial management more efficient through the right technology and operational changes. To avoid costly backlogs and lost revenue, providers need to reduce their overall denial rate and zero in on what’s really driving it and where there’s the greatest opportunity to holistically improve claims management and AR.

Like all RCM challenges, the root causes of denials are fundamentally interconnected – and so are these 7 strategies to slash your denial rate.

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Denial management is sometimes seen as a purely back-office function – it starts when you receive the denial from the payer.

Well... in healthcare today, denial management has expanded to include preventing or preempting denials, effectively moving the effort upstream to coding and claims-management roles—and even further upstream to front-office functions too. Which makes sense. If you can submit the correct claim (with the right codes and supporting documentation) the first time, there won’t be a denial to deal with.

In the context of outpatient care and planned inpatient services, denial management starts before patients ever arrive for their appointment.

90% of denials are preventable

2 out of 3 denials are recoverable
The most common reasons claims are denied:

- Ineligible/uncovered service
- Prior authorization required
- Claim already included as part of a bundled payment or managed care program
- Lack of demonstrated medical necessity
- Incomplete/inaccurate demographic information
- Service covered by another plan/payer

“ZirMed’s automatic eligibility checking is a great thing to have. With just one push of a button, all of the information we need is right there.”

– Multi-provider practice, ZirMed Operations client survey

Nearly all eligibility-related information can be uncovered and confirmed prior to the time of service – by leveraging effective and accurate patient eligibility verification technology.

Even if the full information isn’t verified before the patient arrives, it can be quickly verified or amended as part of the check-in process when the patient arrives – so that the patient knows exactly what to expect, and so that you maximize the likelihood of the most accurate and up-to-date information heading downstream to your coders, billers, documentation specialists, and others involved in your RCM workflows.
#2 MAKE SURE DOCUMENTATION LAYS THE GROUNDWORK FOR SUCCESS

Once the patient’s appointment is complete and the clinical documentation moves downstream to the coder and/or biller, there’s the potential for a bottleneck.

For example, if back-office staff can’t easily view the history and results of all actions taken by front-office staff, they may spend 5-10 minutes simply digging in a different IT system for that information, and compiling it in a spreadsheet or other manual data-entry software before they can move on in their workflow.

There are also a couple ways that clinical documentation can slow things down in the back office. If the documentation doesn’t support the “right” or most appropriate code that should be assigned – or if it simply doesn’t contain the information that is required in order to code and bill for that type of encounter – the staff member(s) working the claim will have to kick it back to the clinician...who, having already provided their full documentation, will have to rack their brains trying to recall the additional detail, sometimes long after the fact.

It may even prove necessary to contact the patient for additional information or to request assistance getting the right additional records from another provider. If this can’t be accomplished, the claim is likely to be denied – and the “best case” scenario is that it adds to staff’s workload for that claim before the claim finally moves down the pipeline and is submitted to the payer.
#3 CATCH CLAIMS THAT WILL BE DENIED

Fantastic – your staff has coded the claim, and made sure the codes are backed up in the documentation. Now you just need to submit to the payer...

...and in 15-45 days you should receive payment...

...or you might instead receive a denial.

That’s 15-45 additional days in AR for that claim...plus 15-45 more days to hear back once you’ve resubmitted the claim/appealed the denial...plus however long it took your staff to identify and work the denial. If you’d had a claims scrubbing engine that caught the error before the claim was ever submitted to the payer, those delays could have been avoided – a matter of minutes compared to an all-but-guaranteed 30-90 day delay if the claim reaches the payer and gets denied.

“Better reporting, better tracking, smoother customer payments, and the ability to catch dirty claims in 30 minutes versus four weeks? For us, choosing and using ZirMed has been a no-brainer.”

– Louisville Gastroenterology & Associates
And remember, if for any reason the denial is related to clinical detail or the encounter itself, that’s an additional 30-90 days that the clinician and/or patient has to think back to recall the detail needed.

So you may want to leverage claims management software that automatically scrubs claims for these kinds of errors – software that understands your payer logic (and updates automatically as this changes). That keeps you and your staff ahead of the curve – as opposed to chasing down denial reasons after the fact and having to contact payers to understand what exactly changed.

“We’ve seen a 20% increase in real-time identification of denials before claims go out the door—no time-consuming interaction with payer required.”

– Amy Myrick, Denial Team Lead
Johns Hopkins Homecare Group

The average cost to work a denial?

$25

Historically, CMS has denied 9.9% of claims.
#4 STOP HUNTING DOWN INFORMATION

Once you’ve optimized front-office and coding/claims-management functions & technology, you’ll have taken the first key steps to reducing your overall denial rate. But some claims will still be denied – which means you’ll need to dig deeper into denial-management processes that have historically made the process of working denials inefficient and time-consuming.

Here are a few figures from a recent study of ZirMed clients across multiple specialties. Per each denial, staff who work denials manually spend up to:

Cutting research time and enabling staff to easily resubmit denied claims are two of the biggest time-

<table>
<thead>
<tr>
<th>Task</th>
<th>Time</th>
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<tr>
<td>Identifying the denial and routing it appropriately</td>
<td>+4 Minutes</td>
</tr>
<tr>
<td>Gathering information</td>
<td>+10 Minutes</td>
</tr>
<tr>
<td>Compiling and filling out appeal letter and materials</td>
<td>+30 Minutes</td>
</tr>
<tr>
<td>Documenting all activity related to the denial</td>
<td>+5 Minutes</td>
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AND VISIT/LOG INTO THE ASSOCIATED PAYER’S WEBSITE TO GATHER ADDITIONAL INFORMATION FOR 25% OF DENIALS

Best Case Scenario for Managing Denials Manually:

49 Minutes per Denial
“My ah-ha moment came when I realized that ZirMed’s root-cause report will eliminate the need for the collections team to manually document everything in a spreadsheet that then has to be manually sorted and analyzed just to drill down to the level where the real reason for denials can be identified.”

– Maria Koehnlein, Reimbursement Manager, DME
Johns Hopkins Homecare Group

savers—period. Automatically providing and populating appeals paperwork can also be incredibly powerful. Ideally, staff should have everything they need automatically pulled together, right at their fingertips.

As recently as 2010, only 35% of providers were actually appealing denials.

WHY!?!?

Working denials the traditional way is expensive and time-consuming.
Remits and EOBs can be another bottleneck in your denial management efforts. If there’s any delay getting the remits into your system – or if paper EOBs end up lingering for some period of time before they’re manually reconciled in the system – you might experience an additional delay before beginning to work a high-value denial, simply because you won’t know it’s there.

Ideally, you should be able to see all of your remits, together, in one place – so that your staff don’t spend time hunting down missing remits. This also ensures a particular claim (and its revenue) doesn’t slip through the cracks simply because the remit didn’t make it into the system.

If you still receive paper EOBs, consider a technological solution to automatically convert them into electronic remits – the less paper, the more efficient your processes and the lower the likelihood of human error.

“Reducing the time we spend conducting follow-up is a huge cost saving. The claims scrubbing and Simple Response messages have dramatically decreased the time it takes to resolve rejections—and helped us reduce our AR days overall. We’ve grown our book of business, but because we’re more efficient, we didn’t have to grow our staff to handle the additional workload.”

– Valerie Johnston, CEO
OptiMed Management
“ZirMed Denial & Appeal Management gives our collectors the opportunity to work the claims in a timelier manner. We receive the denial on average about 10-13 business days before they would have been generated by our cash-posting department in the past. This quick turnaround equates to more appropriate appeal times, and faster revenue recoupment; resulting in an overall lower AR days.”

– Amy Myrick, Denial Team Lead
Johns Hopkins Homecare Group

More appropriate appeal times
Faster revenue recoupment
Overall lower AR days
#6 UNDERSTAND YOUR DENIALS – THEN PLAN YOUR STAFFING

To effectively manage the denials you do receive, you need to identify and triage them based on:

- Likelihood of being recoverable.
- Overall impact on your organization’s financial and performance.
  - Key question: what would happen if there were more denials “like” this one—is it a one-off, or a common type of claim you file with one of your main payers?
- Total probable recoverable/billable amount—what’s the real ROI on working the denial and/or understanding what went wrong?

As you gain insight into payer-specific denial trends and outcomes, you can tailor your approach by payer and even segment the workflow to specific staff where it makes sense—routing the right denial to the right person or team at the right time.

“ZirMed’s Denial and Appeal Management gives us a clear picture of our denials by payer and by branch location, so we can take immediate action on the trends we’re seeing.

“We’re acting on our denials much faster than before. When we had to rely on our AR Aging Reports, we would focus on the older buckets of 30 days or more. Now, we can handle denials long before we create and analyze our reports. It’s helping our collectors bring in significantly more money in much less time.”

– Donald Hoskins
Manager, Revenue Cycle Support
Consolidated Health Services
Once you’ve streamlined the entire process leading up to receiving payment, you can go a step further. Many healthcare accounting teams still rely on spreadsheets or other data silos to track and reconcile payments. Data has to be manually added and verified…and if anyone has an out-of-date version, they end up searching for needles in a haystack that doesn’t even contain them.

Across all of healthcare, 20 percent of remittances are still received on paper—and 46 percent of payments are still made via paper check. Financial impact studies have found that paper transactions cost $7.21 more to process than electronic funds transfer/electronic remittance advice (EFT/ERA) transactions.

So, not surprisingly, one key to more efficient and cost-effective RCM is to shift as much of the current paper-based processes to electronic as possible.

Once you’ve gone electronic, you can focus on automating payment reconciliation.
The most time-consuming parts of manual months-end closing include:

- hunting down the information you need.
- aggregating/normalizing all of that information in one place so you can match it.
- and of course, actually matching it.

With intelligent automation comes increased visibility. And with automated processes and aggregation, you’ll not only be able to answer these questions—you’ll be able to accelerate the manual processes that are at the root of the bottleneck months-end closing can create.

You’ll also be better positioned to process and reconcile more of the kinds of payments – something to consider given the continuing shift toward bundled payments.

“With this automated way to reconcile our payments, we’re able to quickly uncover missing remits and get a more holistic view of the revenue cycle. Overall, reconciliation used to be a four-hour daily process and with ZirMed’s Remit and Deposit Management we’ve reduced it to one hour.”

– Candi Bell
Cash Applications Manager
Innovative Senior Care

Ready to Slash your Denial Rate?

Learn how ZirMed helps providers – and check out ZirMed’s Denial & Appeal Management solution today!

CLICK HERE TO GET STARTED

http://info.zirmed.com/denial-appeal-mgmt-08-16

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