Denials Management

Denial Management – An Introduction

The Revenue Cycle & Why Denials Occur

Understanding & Managing Denials

Automated Denial Systems

Case Studies

Sample Internal Audit Checklist
• A chief concern of healthcare organizations today is decreased claims reimbursement due to claim denials.
  – 25% - 40% of all claims are either delayed via editing or are denied.
  – Medicare’s Hospital Outpatient Prospective Payment System
    Claims error rates = (8%-30%)  
    • Coding errors = 56%  
    • HCPCS errors = 89%  
    • CDM-originated = 79%

• Denied claims generally stem from an unhealthy mixture of cumbersome processes, improperly trained employees, and inadequate technology.
  – Up to 90% of denials may be preventable

• Denials effectively delay or eliminate payment and represent high financial risk to the organization since costs have been incurred without payment.
  – 67% of denied claims are recoverable

• Aside from the direct impact from the loss of revenue, there’s an additional impact on resources because of the expense associated with reprocessing denied claims.
  – 50% of denied claims are never re-filed

• Denials management has become common practice in many healthcare organizations.
• However, the challenge of how to accurately and quickly identify the sources of the denials through comprehensive analysis still remains.

• Fixing the billing problem, therefore, means determining the underlying root causes and then directing resources toward those areas.

  Identifying and removing obstacles that will preclude the conversion of revenue into cash is imperative!!
Denials Management

The Revenue Cycle & Why Denials Occur

The Revenue Cycle is a sequential process beginning with the patient entering the health system and ending with the collection or write-off of the last dollar.

Critical Points to Consider in Patient Access:
- Patient data obtained
- Patient Pre-Registered
- Pre-authorization obtained
- Insurance eligibility and benefits verified
- Patient is notified of financial responsibility
Recognize the importance of coordinating data for clean claims:
- Charge Entry & Late Charge Entry
- Accurate coding of procedure or service
- Completeness of medical documentation
- Timely medical record diagnosis coding

Recognize the importance of creating clean claims:
- The patient demographics must be complete.
- The insurance information must be complete and it must be documented in the system as verified.
- The final diagnosis has to be present on the account.
- There must be charges on the account.
- The contractual timely-filing requirements must be met.

Denials Issue 1: Meeting Payer Requirements
- Patient demographic information not accurately captured.
- Patient eligibility – incorrect primary/secondary insurance or existing coordination of benefits (COB).
- Pre-authorizations/certifications may be required to comply with the patient’s policy.
- Notification of the patient’s admission may be required within a certain time period by some payers.
The Revenue Cycle & Why Denials Occur

Denials Issue 1: Meeting Payer Requirements (cont.)
- New, expensive equipment or drugs may require prior approval.
- Many contracts specify the type of setting in which the patient should be treated, such as – inpatient vs. outpatient.
- Occasionally, a patient in a psychiatric unit requires treatment for a medical condition. The patient may need to be transferred to a medical unit before the payer will cover the treatment.

Denials Issue 2: Claims Mishandling
- Charges that are entered after the initial claim was dropped.
- Unclean Bill – billing errors/omissions
- Use of incorrect billing codes
- Bundling and Unbundling
- When a patient has overlapping dates of service that are not identified and billed correctly.

Denials Issue 2: Claims Mishandling (cont.)
- If documentation does not support the treatment or service provided.
- Missing documentation – medical record, op report, implant invoice.
- When the wrong insurance plan code is used to identify the patient’s insurance. For example, A patient is admitted with a Secured Insurance HMO. The system has three Secured Insurance plan codes to select from: Secured Insurance Indemnity, Secured Insurance PPO, and Secured Insurance HMO. The registrar selects the Secured Insurance Indemnity plan code which can result in a denial from the payer.
The Revenue Cycle & Why Denials Occur

Denials Issue 3: Information System Errors
- CDM changes are not entered timely
- Pricing is inaccurate
- Contract information not loaded properly or updated
- Fee schedules not loaded properly or updated
- Incorrect billing address or transmission to EDI claims clearing house

Denials Management

Understanding & Managing Denials

Effective denials management requires:
- Knowledgeable, well-trained employees to function successfully.
- Preventive measures as well as back-end appeal processes.
- Feedback supported by a mechanism to track and trend the occurrence of denials.
- System of checks and balances that can help to ensure accurate and prompt payment.
Measure the incidence of denials to:
- quantify problems
- detect new problems
- alert management
- compare organization’s performance with that of other organizations
- benchmark data for the incidence of denials or the success of appeals
- set goals using internal benchmarks to compare current with historic performance

Denial Management Process Flow

Identify Root Cause

Employee errors at the front end are one of the main reasons.
- Accepting an expired insurance card
- Transposing a digit (social security #, insurance id #)
- Verify insurance coverage at every registration
- Making sure claimant group numbers were updated.

Solution

Improved training and education go a long way toward fixing problems at the front end.
Understanding & Managing Denials

Identify Root Cause

- Lack of Medical Necessity
- Missing CPT Modifiers
- Incorrect Diagnosis
- Missing National Provider Identifier (NPI)

Solution

- Understand the source documents that govern:
  - CMS Medical Necessity compliance
  - Correct Coding Initiative
  - HIPAA (Health Insurance Portability & Accountability Act) compliance

Denied Claims

Identify Root Cause

- Lack of policies and procedures at the back end are some reasons for improper denial write offs:
  - Untimely Filing of Appeals
  - Write-off Approval Not Formally Documented
  - No Policy to Determine Timing of Denial Write-offs as Not Recoverable.

Solution

- Develop a formalized policy and process for timely filing of appeals, documentation and approval for timely write offs of denials.

Denied Claims

Understanding & Managing Denials

Leading denials management internal auditing practices:

- Conduct a periodic internal audit of your denials and appeals measures through review of remittance advices and other records of claims submission and denials, such as EDI edit reports.

- Annually bring in an external party to conduct an audit for validation purposes. This independent audit serves as a litmus test for internal measures to give senior management confidence in the effectiveness of these critical measures of the denial problem.
Automated Denials System

An automated denials system begins with:

• Automated eligibility verification
  – Online verification occurs in the background with the payer during the scheduling process, allowing the scheduler to validate insurance coverage while the patient is on the phone making the appointment.
  – Any eligibility errors (e.g., wrong member number, wrong insurer, or plan number) can then be addressed while the patient is still on the phone.
• A claims scrubber
  – Software that performs customized edits of the claims data and format so they will be submitted to the carrier as error-free as possible.
  – For example, if a hospital service or supply item has been coded wrong, a code is missing, or medical necessity is not appropriately documented, the software can catch that error before it is billed.

Automated Denials System

• An automated denials management system can perform carrier-specific edits to:
  – Identify denials by root cause
  – Classify and sort denied claims by reason
  – Route the claims to the appropriate department for review
  – Track and prioritize denials
  – Avoid out-of-timely filing
  – Devise a payer report card, focusing on such areas as accounts receivable days for a particular carrier and the carrier’s denial rate
  – Generate a denials aging report, which can be helpful when reviewing accounts receivables.
  – Provide accurate and timely statistics for executives
  – Analyze the effectiveness of denials resolution
  – Identify business process improvements to avoid future denials
Internal Audit Scope - Review the adequacy of policies and procedures as well as internal controls related to the front end processes within XYZ Hospital (XYZ) denial management function. The objectives for this internal audit include the following:

- Review the policies and procedures related to front end processes within the XYZ denial management function.
- Interview appropriate XYZ personnel in order to gain an understanding of and be able to document the processes and internal controls related to the front end processes within the XYZ denial management function.
- Select a sample of denied claims received by XYZ to review whether existing policies and procedures were followed and to document the underlying basis for the denial as well as to provide recommendations for additional controls designed to decrease denials.

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<th>Finding Title</th>
<th>Observations</th>
<th>Recommendations</th>
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| Policy and Procedural Guidance| There is no formal procedural guidance for the front end processes at XYZ, including, but not limited to the following processes: pre-registration, obtaining prior authorizations, performing insurance verification, identifying secondary payors, etc. | - Develop formal procedural guidance for the front end processes at the departmental level: pre-registering, obtaining prior authorizations, performing insurance verification, identifying primary and additional payors, confirming insurance benefits/coverage, etc.  
- Conduct employee training on a periodic basis.  
- Maintain a consistent up-to-date Medicare, Medicaid, and other payor regulations and guidelines. |
### Case Study 1 - Denials Management Front End Review

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<td>Front End Processing, Testing Results</td>
<td>From our total sample of xx denied claims, yy denied claims from the selected departments are denials as a result of no insurance verification prior to the time of services.</td>
<td>Develop formal procedure guidance that addresses verifying specific insurance benefits including: how to determine benefits by payor, how to differentiate between different plans offered by the same payor, how exceptions (if any) should be handled, etc.</td>
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<td>New denied claims from the selected departments are denials that are a result of covered benefits unique to specific payor contracts.</td>
<td>Develop a formal procedural guidance that addresses verification of insurance benefits and coverage.</td>
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<tr>
<td>New denied claims from the selected departments are denials that are a result of incorrect designation of payors as primary vs. secondary or tertiary coverage.</td>
<td>Develop formal procedure guidance that addresses the identification of primary vs. other coverage including: how to differentiate between primary vs. other for specific payors, how to apply the &quot;birthday rule,&quot; how to verify the type of coverage via online information, how exceptions (if any) should be handled, etc.</td>
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<td>New denied claims from the selected departments are denials that are a result of incorrect account setup based on the type of insurance coverage (e.g., worker’s compensation, etc.).</td>
<td>Develop formal procedure guidance that addresses unique account setup including: criteria for setting up worker’s compensation, behavioral, hospice accounts, and other specific account types, how these accounts should be verified, how exceptions (if any) should be handled, etc.</td>
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### Case Study 2 - Denials Management Back End Review

**Internal Audit Scope** - We reviewed the policies and processes related to denials management at ABC Hospital (ABC) to determine the adequacy of internal controls. The objectives for this internal audit include the following:

- Interview staff in the Patient Accounts and other departments to gain an understanding of the denials management functions.
- Document the denials process flow through the various departments from front-end to back-end systems.
- Determine whether adequate internal controls are in place to process and monitor denials management processing functions.
- Review denial codes, root cause identification, resolution process, denials reporting to management and communication processes to relevant departments.

- Review the denial code development and resolution process with responsible department managers.
- Review a selection of denials to determine appropriate categorization of denials and application of resolution process and communication per ABC policy.

### Finding Title | Observations | Recommendation |
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<td>Inadequate process to track denials by reason and volume</td>
<td>There is no process to track denials by reason or to quantify the volume of denials. In addition, statistical and trend analysis are not being communicated to responsible department managers due to system limitations.</td>
<td>Develop a process to track denials by reason code and to quantify the volume of denials. Develop a monitoring process to track appeal rates and their success. Evaluate appeal metrics to identify where additional resources could be allocated as well as to identify denial reasons that are not cost effective.</td>
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| Incorrect assignment of root cause | Denied claims that were written off revealed that their root cause of denial was incorrect. The following were written off due to:
- Timely filing limitation, actual root cause should have been patient registration
- Timely filing limitation due to incorrect coding, actual root cause should have been utilization review
- Non-covered services, actual root cause should have been patient registration | Reassess the current denial categories to determine if they accurately encompass all the major types of denials. Consider adding additional denial categories that address denial reasons that are not cost effective and reviewing root cause. |
| Inadequate communication of root cause | Denied claims that were written off revealed that their root cause of denial was incorrect. The following were written off due to:
- Timely filing limitation, actual root cause should have been patient registration
- Timely filing limitation due to incorrect coding, actual root cause should have been utilization review
- Non-covered services, actual root cause should have been patient registration | Reassess the current denial categories to determine if they accurately encompass all the major types of denials. Consider adding additional denial categories that address denial reasons that are not cost effective and reviewing root cause. |
### Case Study 2 - Denials Management Back End Review

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<td><strong>Untimely Filing of Appeals</strong></td>
<td>Denied claims that were written off revealed that the appeals had not been filed in a timely manner. Currently, ABC does not have a formalized process for timely filing of appeals or assessing the likelihood of success in overturning a denial.</td>
<td>Develop a formalized policy and process for timely filing of appeals and assessing the likelihood of success in overturning the denial. Designate an individual from the denials team to generate a periodic summary report of sustained denial cases, with an in-depth analysis summary.</td>
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<td><strong>Write-off Approval Not Formally Documented</strong></td>
<td>Claims revealing the approval of write-offs related to appeals and the related threshold limits are not formally documented. Currently, each Specialist is able to write-off accounts up to $100,000 without Supervisor’s approval. Accounts over $100,000 are transferred to the Supervisor’s work list for approval.</td>
<td>Develop a formal policy that documents write-offs and the criteria that define the dollar limit of denied claims that each level is authorized to write-off. Communicate the policy and the related procedures to all affected ABC employees. Periodically review different threshold approvals to validate write-offs were appropriate.</td>
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<td><strong>No Policy to Determine Timing of Denial Write-offs as Not Recoverable.</strong></td>
<td>ABC does not have a formal process to determine or identify when to write-off denials that are not recoverable. Closed out accounts from outsourced vendors that were deemed not recoverable are placed on hold until management decides to write-off is determined. This process is not systematic and inflates aged receivables.</td>
<td>Develop a policy that defines the criteria that determine the timing for writing off denials as not recoverable. Generate periodic reports of aged accounts over 91 days for review and management approval prior to write-offs.</td>
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<td><strong>Write-Off of Self-Administered Drugs</strong></td>
<td>Denied claims that were written off revealed that charges for self-administered drugs that were denied by Medicare were written off instead of being billed to the secondary insurance and/or the patient.</td>
<td>Formalize in writing the practice of billing self-administered drugs to the secondary insurance and/or the patient. Educate the billing department of this new policy.</td>
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<td><strong>Write-Off of Non-Covered Services</strong></td>
<td>Denied claims that were written off revealed that non-covered charges that were denied by Medicare and were written off instead of being billed to the secondary insurance or the patient.</td>
<td>Develop a policy to bill the secondary insurance or the guarantor for charges that are denied by Medicare as non-covered services. Designate billing staff to review non-covered service denials to determine if they can be billed to the secondary insurance and/or the patient.</td>
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<td><strong>Delay in Filing of Claims</strong></td>
<td>Denied claims that were written off reflected delays of over a month before the charges were dropped. The Aging by Payor Report as of June 30, 2008 showed total amount of $100M comprised of $50M “not billed” and $25M “not discharged”. Currently the bill hold guideline for final bills is 7 days after discharge. However, the system has a guideline of 365 days for all bills waiting to be abstracted from Medical Records.</td>
<td>Consider reducing the bill hold days for not abstracted bills from Medical Records consistent with timely filing guidelines from all payors. Evaluate reasons for claims “not billed” and “not discharged” as of June 30, 2008 and ensure claims are billed timely. Develop a periodic (monthly) report that details claims with outstanding charges and the days since the discharge date.</td>
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Sample Internal Audit Checklist

- The following include some examples of areas that health systems should include in the testing portion of their internal audit programs related to denials:
  - **Policies & Procedures**
    - Up-to-date organizational policy and comprehensive/detailed procedural guidance related to processes designed to reduce denials
  - **Patient Access**
    - Complete and accurate patient demographic information
    - Pre-registration performed
    - Pre-authorization for services obtained (when required)
    - Insurance eligibility and benefits verified
  - **Point of Service**
    - Timely charge entry and late charge entry
    - Accurate coding of procedure or service
    - Completeness of medical record documentation
    - Timely medical record diagnosis coding

Sample Internal Audit Checklist (Continue)

- **Patient Accounts**
  - Complete and accurate patient demographic information
  - Insurance information documented and verified
  - Final diagnosis documented on the account
  - Charges for the account are complete and accurate
  - Contractual timely-filing requirements must be met

- **Denials Management Reporting & Tracking**
  - Report and track denials by root cause
  - Report and track denials by reason
  - Prioritize and track resolution of denials
  - Route denied claims to appropriate department for required follow-up
  - Develop a denials aging report and the impact denials have on A/R
  - Develop a payer report card, including A/R days and denials for each payer
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