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DENIALS MANAGEMENT: REVENUE INTELLIGENCE

Six Rules for Successful Denials Management: How to Get from Revenue Integrity to Revenue Intelligence

By: Beverly J. Bredenfoerder, Vice President, Audit Operations

For health systems and hospitals, claims denials have a significant impact on overall financial performance.

From lost charges and Medicare/Medicaid cost outliers to defensive and forensic audits, the impact can reach into the tens of millions of dollars for large systems. The regulatory consequences can also be quite harsh. **That's why an effective approach to denials management is so important.**

When denials are successfully appealed and overturned, health systems receive direct and tangible value in the form of increased revenue. Further, when proven tactics and strategies are applied as part of ongoing coding and billing processes, they reduce the number of rejected claims, eliminate the need for distracting third-party audits and increase overall revenue integrity. That's a win-win-win for patients, payers and providers.

But the reality is that claims denials are an inevitable part of the healthcare landscape today. And they can be difficult to overturn, given the complexity of billing codes, payer relationships and certain cases. Still, hospitals and health systems that adopt leading practices and proven tactics – what we call "the new rules of denials management" – can increase the likelihood that denials will be overturned and that claims will be accepted and paid the first time. Plus, they'll learn to navigate the most common causes of denials, such as medical necessity and lack of authorization. The six rules are:

1. **THERE'S NO SUBSTITUTE FOR EXPERIENCE.**
2. **CODING AND OTHER SPECIALTY EXPERTISE IS ESSENTIAL.**
3. **TRACKING AND REPORTING CLARIFY WHAT WORKS.**
4. **DENIALS MANAGEMENT STARTS WITH BILL SUBMISSION.**
5. **MINOR DETAILS CAN HAVE A MAJOR FINANCIAL IMPACT.**
6. **STRONG DENIALS MANAGEMENT PRACTICES CAN STRENGTHEN STAKEHOLDER RELATIONSHIPS.**

Our highly experienced revenue integrity team has used these principles in achieving a success rate of 60-80% in overturning appeals and recovering and protecting up to $10 million annually for our hospital clients. Our approach helps hospitals optimize their financial performance while streamlining compliance processes and enhancing payer relationships.

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1 THERE'S NO SUBSTITUTE FOR EXPERIENCE.

Why it matters: Because there are so many moving parts and important details in denials management and revenue auditing, experience is essential to both efficiency and effectiveness. Experience means knowing where to look in specific cases, as well as recognizing broader patterns in denials. For instance, experience means knowing the considerable differences between commercial and government payers and between inpatient and outpatient procedures.

What to look for: Ideally, denials teams are comprised of professionals with at least 3-5 years of relevant nurse audit experience and have auditing and coding credentials such as CMAS (Certified Medical Auditing Specialist) and CCA (Certified Coding Associate).

And because coding standards and guidelines change every year and leading practices evolve constantly, all members of denials management teams should undergo continuing education and regular training. Because of these qualifications and steps, the most experienced auditors and consultants will very rarely experience trends or cases they haven't managed before.

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2 CODING AND OTHER SPECIALTY EXPERTISE IS ESSENTIAL.

Why it matters: The combination of nurse auditing experience and coding expertise is extremely effective in overturning all types of denials, including those for medical necessity, diagnosis and procedure coding, authorization and experimental procedures.

How it works: When denials teams have the right mix of experience and expertise (plus knowledge of relevant issues in clinical documentation improvement), they can more quickly locate appropriate records and data in medical charts to meet specific payer requirements. And if necessary documentation cannot be found in electronic medical record (EMR) systems, the team will know how to engage different departments to find the necessary information efficiently.

The deeper and broader the expertise, the more likely the team will be familiar with payer policies and understand the criteria needed to overturn a denial. For example, some payer policies require photos which are not always included in EMRs and must be requested and located to send with the appeal. It's a faster and more efficient process if denials management teams know in advance what they are looking for.

While it's not practical for hospital compliance and audit teams to have specialty expertise available to help with denials, they should know to call on a wide range of experts when necessary. Those experts can include coding, clinical and medical audit specialists, MDs, CMAs, RNs, LPNs, LPTs, RHIA, CCS, CDS and CDIP.

Revenue Intelligence in Action

A major academic hospital and health system on the West Coast turned to UASI to establish a robust denials management strategy for both government and commercial claims. The UASI team, which combined nurse auditing and coding expertise, worked with the hospital team to:

- Identify the most common causes of denials
- Establish data gathering processes to collect the necessary information
- Track the success of various appeals strategies
- Create recommendations for future denial prevention

The results? A 60-80% success rate led to millions of dollars of recovered revenue, clearer visibility into claims and billing performance, and more confidence about overall revenue integrity. For every dollar the hospital invested with UASI, it received back 35 from commercial payers and 9 from government payers.

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3 TRACKING AND REPORTING CLARIFY WHAT WORKS.

Why it matters: When denials management is viewed as an organizational capability, rather than a series of one-off cases, hospitals and health systems can continuously improve their appeals strategies. Plus, they can learn to submit more accurate bills in the first place. In other words, tracking and reporting should be viewed as part of a virtuous circle of revenue auditing and denials management.

How it works: Tracking appeals over time clarifies which are upheld or overturned and why (e.g., by CPT code and different types of payers). These insights can then inform future appeal strategies, including the judgment of when appeals are appropriate and likely to succeed and when they are likely to waste resources and time.

Beyond the number of appeals and overturn rates, denials management reports should detail a number of factors, including:

- Top reasons for denials based on volume and dollar amount
- Top codes that have been denied
- Denials by accounts
- Trend analysis

They may also highlight denial and appeal strategies, as well as those cases where appeals are not appropriate or not likely to succeed. The big idea: denials management reports should be designed to provide information that helps improve turnover rates and enhance denials management strategies over the long term, not just for individual cases or one quarter at a time.

4 DENIALS MANAGEMENT STARTS WITH BILL SUBMISSION.

Why it matters: Through tracking and reporting and the input of skilled and experienced teams, hospitals and health systems can optimize their coding and billing practices so they have fewer denials to manage. The key is to apply lessons learned from successful appeals and instill them as part of ongoing processes so mistakes are not repeated.

How it works: Concurrent auditing principles should be applied to identify potential denial criteria before initial bills are submitted. Again, reporting and tracking play a key role. For every appeal, denials management teams should report back with specific actions that can be taken to prevent future denials, with guidance on diagnostic and procedure codes and payer type.

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5 MINOR DETAILS CAN HAVE A MAJOR FINANCIAL IMPACT.

Why it matters: Because of the complexity of healthcare coding, the many small details can add up to big financial impact. For instance, relevant policies, LCDs, NCDs, InterQual criteria, diagnosis and procedure coding hold the keys to determine the reason for denials and design appeals strategies.

How it works: Denials management teams must examine all relevant documents to support every point of the criteria needed to comply with each and every payer's policy for specific procedures to be appealed. That means organizing and listing everything so payers have a complete rebuttal in hand when they first receive appeals.

Attention to detail pays off in many common cases, such as when procedure or diagnostic coding errors lead to denials based on lack of medical necessity. Similarly, payer policy documents can often be used to overturn claims denials based on lack of authorization and medical necessity. In one case, a large academic health system was losing $20,000 of revenue for every gastric bypass surgery claim simply because they were applying the wrong criteria.

Error-free billing also pays off by freeing hospital and health system resources from having to spend time with third-party audit firms.

Our experience teaches us that hospitals and health systems can expect very strong returns on every dollar they invest in denials management and appeals strategies, ranging from 25-35x for private insurance and 8-10x for government payers.

6 STRONG DENIALS MANAGEMENT PRACTICES CAN STRENGTHEN STAKEHOLDER RELATIONSHIPS.

Why it matters: An effective denials management approach improves the image and perceptions of hospitals and health systems in the eyes of critical stakeholders, including payers and regulators.

How it works: By sharing information about denials from both government and private payers, hospitals and health systems can improve relationships with state Medicare Administrative Contractors (MACs). Health systems may face fewer audits if they demonstrate knowledge of requirements for medical necessity and other common causes of denials. In some cases, payers and regulators may consult with the health systems on matters of shared interest.

Appeals don't have to be adversarial; in fact, they can be quite educational for all parties. Payers are usually receptive to appeals when they are well researched, provide well organized documentation, include all required information and make a clear point about why denials should be overturned. Efficient appeals also benefit payers in terms of reducing their administrative burdens.

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THE BOTTOM LINE: GETTING FROM REVENUE INTEGRITY TO REVENUE INTELLIGENCE

Denials management is a discipline where hospitals and health systems stand to realize significant upside if they can improve their capabilities. Unfortunately, that's not easy. It requires deep experience, access to specialty expertise and the ability to capture and apply lessons learned for continuous improvement. In other words, denials management pays off not just in terms of recaptured revenue, but also by improving overall process efficiency and effectiveness.

That's why we encourage our clients to think in terms of "revenue intelligence" – that is, a data-driven and technology-enabled approach to revenue integrity. Such an approach incorporates proven strategies and tactics for managing denials and appeals, as well as for conducting all types of audits. While revenue integrity is critically important to health systems, we believe revenue intelligence will become even more valuable in the future.

About the Author

Beverly J. Bredenfoerder, Vice President, Audit Operations

Beverly joined UASI in 1996 after holding key executive roles with regional managed care organizations. Beverly's experience from the payer's perspective has developed UASI into the regional leader for medical billing audit services serving an impressive list of nationally recognized healthcare providers. Beverly is a graduate of the University of Cincinnati.

ABOUT UASI: SETTING THE STANDARD FOR REVENUE INTELLIGENCE

- **Headquarters:** Cincinnati, Ohio
- **Founded:** 1984
- **Clients:** 200+ hospitals/health systems nationwide
- **Team:** 450+ employees, including Certified Medical Audit Specialists (CMAS) representing expertise in charge capture, denials management and revenue intelligence
- **60-80%** success rate in overturning appeals to recover millions in annual revenue
- **Experience:** management team averaging 35 years and consultants averaging 20 years of experience
- **Quality:** 100% coverage — we engage the experts needed for each assignment
- **Reliability:** 35 years in business and 40 clients in US News & World Report best regional and honor roll hospitals
- **Culture:** people-centric, team-driven, with high employee satisfaction and industry-leading average employee tenure

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