Five reasons claims are denied – and how to prevent them

Claim denials plague health care providers nationwide, siphoning up to 5 percent of patient net revenue per year and causing a cycle of rework on roughly 20 percent of claims[1]. Couple that with the troubling statistic that upwards of 50 percent of denied claims are never worked by hospitals[2], and the scope of the issue becomes clear: denials management is vital to the financial health of your organization.

50% of denied claims are never worked by hospitals

5 reasons

Demographic errors
Coding errors
Authorization requirement
Medical necessity
Eligibility and incorrect insurance

5 strategies

Understand the root cause of denials
Drive excellence in front-end operations
Unify tools to streamline results
Track your data
Make it a strategic priority

These five underlying reasons drive the most denials. What safeguards do you have in place to avoid them?

1

Demographic errors

Demographic errors are the leading cause of denials and write-offs. It has been estimated that up to 61 percent of denials are due to errors in this category, and over half of those result in write-offs[1]. Contacting a patient to correct his/her information can be difficult, especially once the patient has left your facility. Unresolved demographic errors can resurface to cause issues at every step in the billing process, further increasing the likelihood of a denied claim.

2

Coding errors

Coding errors are another major cause of denials. Coding errors in the form of incorrect diagnoses, missing code modifiers and incorrect CPT codes cost one health system $3.5 million[3]. It has been estimated that almost 42 percent of Medicare E&M services claims per year are coded incorrectly, including upcoding and downcoding errors[4]. Physicians and care providers are working in a fast-paced environment, often with outdated tools and software, which can cause them to miss vital documentation details.

3

Authorization requirement

Authorization requirement denials are often due to increasingly complex requirements from payors. It has been estimated that authorization activities average up to $3,430 per physician[5]. Fulfilling these requirements prior to rendering a service is time consuming, and payors update requirements at any time with little communication, causing confusion and delays. Some states – including Arizona, Maryland, Texas and Washington – have proposed plans or rolled out requirements for statewide standardized authorization forms and electronic filing systems.

4

Medical necessity

Medical necessity denials are often due to poor internal processes and documentation. Specificity is required to inform a submitted claim, and erroneous or vague information will result in a denial. If a payor concludes a patient could have been treated at a lower level of care or that there is a lack of evidence that the chosen treatment plan was required, a medical necessity denial may result.

5

Eligibility and incorrect insurance

Eligibility and incorrect insurance issues are estimated to drive roughly 16 percent of denials[2]. This can be due to dates of coverage misaligning with dates of service, out-of-date insurance carrier information on file for the patient or out-of-network providers rendering services to patients in a limited access plan. Individual services can also be carved out, or not covered, resulting in an eligibility denial. Coordination of benefits denials occur when a secondary payor on the patient account is billed as a primary payor or without primary EOB information – another complication that may arise as a result of billing insurance incorrectly.

Denials claim up to **5%** of patient revenue **per year**

Proactively optimize your billing and claims management processes to improve denials. Here are five specific strategies.

1

Understand the root cause of denials

Understanding the root cause is the first step to improving denial management. Mapping tools can pull information from the denied claim and assign each denial to an appropriate work queue by reason, reducing turnaround time to resolution. Utilizing an advanced denials mapping tool that pulls from many factors on the Explanation of Benefits (EOB) and assigns each denial to a work queue based on business rules that reflect your specific contracts can further increase collections efficiency.

2

Drive excellence in front-end operations

Accurate patient registration decreases demographic denials. Operational efficiencies in registration and check-in also increase patient satisfaction and optimize patient safety and privacy. And this is not just at check-in; all work areas that can trigger denials (verification of benefits, prior authorization, coding, contracting) should partner to ensure patient data and documentation remains accurate.

3

Unify tools to streamline results

Optimize your ability to resolve denials more quickly with a unified platform, integrating claims, collections and contract management data into a single view. Assess denials at a net (versus gross) amount to properly prioritize areas that are affecting your revenue. Establish rules to ensure appropriate completion of edits to improve your clean claims rate over time. Use automated workflows to identify potential denials early and prioritize collector workloads to ensure resources are appropriately allocated. Generate timely appeals for the most appropriate accounts based on business rules specific to your payors and your program.

Hospitals who see success in denial avoidance study what they know about their denials and use those insights to target bottlenecks or poor processes upstream.

4

Track your data

Trends in payor data over time can be used to make projections about future expected payments and potential payment issues. Assess outcomes to determine if resource utilization is achieving results. Since tackling one known denial category can result in increasing denials in other areas, the delicate ongoing balancing act requires regular review of real-time data to stay ahead of impactful changes.

5

Make it a strategic priority, not just a short-term project

Data driven from proper denials management can be used to target operational changes and strategic technology investments, and can even drive change with payors. Leverage your data insights with payors to eliminate contract requirements that often lead to denials overturned on appeal. Level-set with upstream leadership to understand where bottlenecks are occurring and work together to improve data accuracy and reduce the chance of denials at every step.

1 Gooch, K. (2016, July 26). 4 ways healthcare organizations can reduce claim denials. Retrieved from Becker's Hospital CFO: http://www.beckershospitalreview.com/finance/4-ways-healthcare-organizations-can-reduce-claim-denials.html

2 Richelle Marting, J. M. (2015, March 2). The Cure for Claims Denials. Family Practice Management, 7-10. Retrieved from Family Practice Management: http://www.aafp.org/fpm/2015/0300/p7.html

3 Healthcare Finance News. (2015, December 7). Getting in Front of the Problem: How Can Hospitals Empower Denial Prevention and Management? Retrieved from Healthcare Finance News: http://www.healthcarefinancenews.com/sponsored-insights/getting-front-problem-how-can-hospitals-empower-denial-prevention-and-management

4 Verdon, Daniel R. (2014 June 2). Significant Medicare coding errors signal need for physician education, OIG says: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/coding/significant-medicare-coding-errors-signal-need-physician-educa?page=full

5 Christopher P. Morley, P. D. (2013). The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies. Journal of the American Board of Family Medicine, 93-95.

nthrive™

Engage with nThrive

Visit www.nThrive.com **E-mail** solutions@nThrive.com

From Patient-to-Payment,℠ nThrive empowers health care for every one in every community.℠