



Raising the Bar to Increase Claims Revenue

Four Steps to Achieving Better Denials Management

By Jim Denny

If you're a revenue cycle expert, you may not know that one in every five people globally has an active Facebook account, or that one in five Americans has allergies or asthma. But you probably have heard this industry standard: Commercial payers incorrectly process one in five claims submitted by physician practices.

This number, tracked by the American Medical Association, has begun to improve in the past few years, decreasing to 7.1% in 2013. As the health care industry has worked to improve the percentage of correctly paid claims, providers also can raise the bar within their practices to reduce denials. In today's demanding environment, practices are seeking ways to reduce costs and do more with less—and recovering revenue from denied claims can have a substantial financial impact. By combining

technology with processes changes, practices can potentially eliminate reasons for nonpayment and recoup denied claim revenue today, while becoming better prepared for industry challenges such as ICD-10 tomorrow.

1. Streamline and Automate Eligibility and Medical Necessity Determination

Eligibility lays the critical foundation for collecting from both sources of a practice's revenue: patients and payers. If staff must verify eligibility manually, however, the time and effort required can hamper your practice's financial health. One physician practice, for instance, averaged 90 to 120 accounts receivable (A/R) days prior to automating eligibility checks. Post-implementation, their A/R average was 20 to 40 days—and in addition to accelerating collections, they increased the collections as well.

Through electronic eligibility, busy practice staff can verify a patient's demographic data along with payment responsibility in near real time, and then provide a written estimate for review and sign-off. At the same time, these data collected at registration can be integrated into the practice management system and EMR, which can yield several benefits.

This data integration eliminates rework such as manually posting copays and balances. It also helps ensure the accuracy of patient demographic data, providing an extra step of verification in the practice management system before claims submission. Even an incorrect ZIP code can cause a denial; therefore, fewer manual touches of data can help reduce denials by removing opportunities for human error.

Lastly, practices can leverage sophisticated claims editing tools to further scrub claims before they're sent to the payer. These tools can identify problems with medical necessity or National Correct Coding Initiative edits, along with proper diagnosis usage such as gender,

age, specificity, and manifestation. By performing these reviews, many of which may be included in the scrubbing performed by a clearinghouse, a practice can greatly reduce the chance of submitting improper claims while placing minimal demands on its staff.

2. Establish Expediency in Posting Payments and Nonpayment Reasons

In a perfect world, practices could eradicate denials through up-front processes. In reality, the best way to cope with unavoidable denials is to act quickly. Follow best practices for payment posting; for instance, load all fee schedules so payment accuracy can be verified. Use electronic 835 and electronic funds transfers whenever they are available, and post electronic data when deposits and amounts are verified as received within 24 hours.

Regarding nonpayment or underpayment, the same rules of expediency apply. Set up a denials follow-up process, giving staff access to data so they can identify and track denial reasons and accompanying remarks. By accessing and acting on unpaid and underpaid claims quickly, you can minimize their impact on your A/R days. Once your staff has a consistent workflow in place, they'll know with clarity what action they should take—and won't need to fall back on write-offs.

3. Streamline the Appeals Process

In the past, not all practices had a disciplined and dedicated appeals management initiative; they may not have had the option due to the resources required. Fortunately, technology can facilitate much of the tedium and time-consuming tasks. Today's appeals management tools can set up work lists that assign particular appeals to staff's queues, allowing practices to tailor and prioritize appeals management according to their specific strategy. In addition, besides guiding workflow, these work lists can also

create accountability. For instance, if practice leadership decides a supervisor must sign off on pursuing a certain type of claim, this action is built into the work queue.

Last but not least, these tools can provide built-in assistance such as prepopulated appeal letters, supporting documentation such as an explanation of benefits and claims history, libraries of payer-specific forms, and professionally written letters based on denials categories. While appeals management is an inherently detailed process, giving staff the tools to simplify their tasks can help them achieve better results faster—and potentially avoid burnout.

4. Monitor, Analyze, and Take Action

Conducting a regular claims analysis on a monthly or quarterly basis is a discipline that will pay off in dividends. These analyses will reveal the main causes of denials, denial patterns per payer, and whether errors are sourced from the practice or payers. Going a step further, you can view staff's follow-up actions for various types of denials to see if their responses can be further optimized. These reports are the key to your team's continuous improvement, and they can allow leadership to educate when needed or recognize when a job is well done.

The cliché "raising the bar" exists for good reason. Most of the time—as is the case with denials management—the higher bar is both attainable and worthwhile. As practices face more complex value-based reimbursement models and an ICD-10 transition that may increase denials by 100% to 200%, it's a great time to establish more proactive processes for denials and appeals management. As you put these strategies into practice, your extra effort will pay off in claims accuracy, increased revenue, and preparedness for industry changes.

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