Navigating the World of Denials Management

For many behavioral health agencies serving a high population of Medicaid patients in Ohio, managing claims denials and follow-up is a fairly new concept - at least speaking from the perspective of volume and scale. With the introduction of Medicaid managed care; and the application of new billing and payment rules and regulations, coupled with the implementation pains for both providers and health plans, denials are an unfortunate occurrence that the majority of our agency members are working to manage.

The goal of any well performing revenue cycle is to receive timely and accurate payment for services rendered. To be able to receive timely and accurate payment without having to manually intervene on the claim at any level is ideal. The Medical Group Management Association estimates that it costs an organization $25 each time a claim has to be touched after it has been initially billed. Obviously, multiple claims interventions will drastically reduce your overall return on the claims that you bill out.

Defining the Revenue Cycle

The Revenue Cycle is comprised of all departments, people, and processes which go into producing and receiving payment for a patient claim. This includes:

Revenue Cycle Upstream (or Front-End)

Everything that happens pre-service: patient scheduling, prior authorization, eligibility verification, patient registration;

Revenue Cycle Mid-stream (or Middle)

Everything that happens after registration and before the bill is prepared: clinical documentation, utilization management, charge entry, coding;

Revenue Cycle Downstream (or Back-End)

Everything that happens from the time of billing until the claim is resolved: billing, rejections, cash-posting, denials and follow-up.

All members of the Revenue Cycle team need to be aware of how important their job is in working towards the goal of a clean claim.

Identification, Root-Cause Analysis, & Communication

The key to improving your Revenue Cycle is to identify where the genesis of the denial is. There are three steps involved in working towards that end.

1. Identify the denials accurately and timely

2. Determine the source of the error

3. Communicate with all parties involved to work on a resolution

Easy as 1, 2, 3 - right? Okay, no. So, let's break this down further, because it really is worth the effort.

Identification

We can't fix what we don't know is broken. Identifying the denials is Step 1. Claim denials and rejections can happen at two different places and both offer opportunities for process improvement.

Clearinghouse Rejections

Most clearinghouses run a preliminary claims logic review. Depending on your vendor they will scrub for basic coding inconsistencies (age/gender coding discrepancies, MUE and PTP (NCCI) edits, invalid CPT/ICD-10 codes, etc.). The biller in charge of submitting claim files to the clearinghouse can play an important role of monitoring and reporting trends in these rejections to both their supervisor and to the party at the source of the error.

MCO Rejections & Denials

The plans return their denials and rejections via the ANSI 835 file and should use industry standard adjustment and remark codes. The list is quite long, but "like" remark and adjustment codes can be grouped manually into subcategories to make trending easier.

In the image below, Adjustment Reason Codes 26, 27, 31, 32, and 33 are all related to "eligibility". By creating a subcategory in your reporting system to group these like denials, you can better see the source of the problem and communicate those back to the department responsible for eligibility verification.

26	**Expenses incurred prior to coverage.** *Start: 01/01/1995*
27	**Expenses incurred after coverage terminated.** *Start: 01/01/1995*
29	**The time limit for filing has expired.** *Start: 01/01/1995*
31	**Patient cannot be identified as our insured.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
32	**Our records indicate the patient is not an eligible dependent.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
33	**Insured has no dependent coverage.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

Similarly, the image below shows three different Remark Codes which are all related to Patient Demographics, which could indicate a quality issue in registration. By creating subcategories for these remark codes, you can more easily group "like" denials to research the root cause and address the internal challenges which might have led to the denial.

MA36	**Missing/incomplete/invalid patient name.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA37	**Missing/incomplete/invalid patient's address.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA39	**Missing/incomplete/invalid gender.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*

Source and Root-Cause Analysis

Denials can be categorized into a few of different types.

- Initial or Final; and
- Technical or Clinical; and
- Controllable and Non-Controllable

Initial Denials, while requiring re-work, still allow for the opportunity to appeal or request a reconsideration for payment. Your initial denial rate is the inverse of your clean claims rate. It is important to review these denials timely and thoroughly to ensure that you can correct any claim issues (if required); or request a reconsideration before the timely filing limit has expired. Overtime the goal is to continually lower your initial denial rate, this directly impacts your cost-to-collect.

Final Denials are write-offs. These are denials that cannot be appealed or reconsidered. Be sure to differentiate between your true denial "write-offs" vs. your "contractual adjustments". Your Contractual Adjustments (the difference between what you charge and what the plan has agreed to pay) is an expected adjustment, and should be monitored separately from your denials.

Technical Denials are administrative type denials and are typically controllable, meaning - with improved education and process enhancements your organization should be able to reduce and/or eliminate these. Technical denials are related to things like eligibility, demographics, modifier application, missing authorizations, etc. By categorizing your remark and adjustment codes you should be able to trend the source of these denials back to the department who typically handles those.

Clinical Denials are more complicated and typically require more specialized knowledge to appeal or overturn. Clinical denials are drive by discrepancies in level of care, or medical necessity. Your clinical team will need to be involved closely on both monitoring these denials and the reason behind them, as well as helping to draft an appeal when appropriate to ensure that the managed care plan has all of the appropriate documentation necessary to review the claim for payment.

Controllable Denials are simply that, denials that could have been avoided. This is where identification and communication go hand-in-hand. It's not enough to identify the issue, the goal with any Revenue Cycle enhancement effort is continuous improvement and working towards lowering the overall denial rate. I recommend that all departments in the Revenue Cycle meet at least monthly to review metrics related to claims performance. Departmental leaders should be advised of areas of improvement which could lead to lowering the controllable denial rate and asked to provide feedback and/or staff training to that end. Ideally, as more challenges are identified and addressed internally, the controllable denial rate should show a continual reduction.

Uncontrollable Denials are those that you, as the provider, have zero influence over. These are typically caused by a problem in the plan processing system. These could be due to a build issue in their rules logic, manual processing errors, provider set up issues, any number of things. These are going to only come to light through the root-cause analysis process because the remark codes and adjustment reason codes are going to look like any other denial. Only through trending plan-wide will the true cause of the denial come to light.

In the last section I will go into different ways to trend your data to identify the root-cause more easily.

Communication. Communication. Communication.

Whether internal among your Revenue Cycle team partners, or external with your plan partners, communication is key.

Internal Communication

Building a rapport between Revenue Cycle departments is key. In addition to the monthly meeting suggestion previously mentioned, it is recommended that a Revenue Cycle reporting package is compiled and reviewed routinely. This package will track things like Days in AR, Clean Claim and Denial Rates, and also error rates by department (based on the sub-categories outlined above); in addition to any other reports deemed critical by your organization.

External Communication

Work to foster a relationship with your MCO partners. Each agency has an assigned "Provider Relations Representative" with each MCO plan. If you do not know who your Provider Relations person is, call the provider relations phone number and ask. They will connect you. If you have a number of open issues which are not being resolved, ask for what is called a Joint Operating Committee (JOC). This is a meeting, typically held monthly, between the provider and the plan to review open issues. Be sure to use an Issues Tracking Log to keep notes on all open issues, who is responsible for resolution, and track them through to completion so that every issue is eventually addressed.

It is also important to do as much pre-work as possible before escalating an issue to a the JOC level, to ensure that the open issue is not controllable. Once verified, identify impact (approximate number of claims, dollars involved, physicians involved, codes, edits, etc.). Track details related to every call or email you send (representatives names, dates you called, ticket numbers, reference numbers, conversation take-aways, next steps, etc.). If ever the question of timely filing comes up, you want to be able to show that you were actively engaged in resolution.

Data-mining and Denials Trending

Data-mining and denials trending can be done using something as sophisticated as an automated work-queue or something as simple as an Excel worksheet. I find this is most accurate when reviewed by plan. Many follow-up and denials teams are structured by plan because issues are often systematic; meaning - there is a common issue involved and therefore likely to impact multiple claims at a time. Additionally, plans typically assign the same adjustment and remark codes consistently based on their proprietary logic. While they are all held to the same ANSI-X12 standards via HIPAA, that only applies to the code set used. Not necessarily how they are applied.

I recommend pulling in the following fields at the charge line level by payor:

- date of service
- cpt/hcpcs code
- modifier 1
- modifier 2
- charge amount
- adjustment code amount
- denial reason code
- billing provider NPI
- rendering provider NPI

Then you can begin sorting and pivoting to look for trends. The process is somewhat manual. You're trying to see what is driving the denials. Are you experiencing a pre-auth denial for all services performed by Dr. Smith? Perhaps there is an issue with the provider's profile? Does a particular CPT/HCPCS only deny when billed with a certain modifier? Are the denial amounts all the same? Group them and see what other commonalities you can find. It's like being a Denials Detective!