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Focus: CFO perspective on denial management

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Title: Flipping the script on denial management

What's in a word? When that word is "denial," it is capable of generating a great deal of negative energy, especially for health system executives in key pain-point positions—like CFOs and revenue cycle directors. Instead of merely managing and tolerating denials as a necessary evil, progressive organizations prevent them from ever occurring. In this way, rational CFOs flip the script on payer denials—viewing them as an opportunity to learn, improve and minimize future revenue risk.

Advancements in technology and data analytics facilitate the transition from denial management to denial prevention. However, an organizational culture of proactive revenue protection must also be in place, beginning with the CFO. According to the CFO of one large, multi-hospital health system, "The last thing we want is to submit a claim, receive a denial, and then have to defend that claim."

This article defines logical, quantifiable strategies to be proactive, analyze data and prevent payer denials. The first step is to shift staff from denial managers to revenue defenders.

Building a denial-prevention team

An effective denial-prevention team comprises individuals from many specialties. It requires solid C-level sponsorship and a multidisciplinary approach.

There are so many elements to a denial-prevention program that no one person or department is solely responsible. Rather, it is a true team effort that should be supported by senior leadership and involve representatives from all aspects of the revenue process. Key participants should include:

- Patient access
- Health information management (HIM)
- Patient financial services
- Discharge planning
- Care management
- Medical staff

With a solid team in place, the next objective is to identify process improvement and educational opportunities to proactively prevent denials. These can be found in virtually every step across the patient journey.

Four areas of focus

Starting with pre-admission, here are four places for the denial prevention team to quickly focus and achieve quantifiable reductions in claims denial risk:

- **Pre-admission—**Denial prevention begins at the physician's office. Getting accurate information up front from the practice is imperative. This information includes but is not limited to: diagnosis, insurance information, correct patient identity and demographics.
- **Patient Access/Hospital Registration—**The admissions process is critical to the revenue cycle department. If the information is not correct, the experience will be bad from the beginning for all parties involved, including patient, provider and payer. Here, the old adage definitely rings true: "Garbage in, garbage out." All of the above information is needed, plus coinsurance, deductible and any outstanding balances.
- **During Encounter—**Once the patient is admitted, the care team is responsible to ensure the patient is provided the optimum level of service from the proper unit. Case managers become a key player in denial prevention. Clinical documentation improvement (CDI) and physicians must also work together to correctly document each diagnosis and procedure in order to support medical necessity, including the two-midnight rule.
- **Discharge Planning—**Discharge planning should match the right level of service in order to reduce chances of readmission. Accurate discharge status, clinical coding and billing are important back-end steps to reduce claims denials.

Analysis of current and prior claims helps identify trends and prioritize improvement opportunities.

The art of predicting denials

When dealing with denial prevention, there is significant room for error and failure to minimize risk. It is imperative that you identify previous denials, and use analytics to help predict new denials. According to Adam Goldman, director of patient financial services at Emory Clinic in Atlanta, Georgia, "Denial prevention isn't only about revenue; it's also about cost-need analytics and workflow management." Denial prevention teams should identify root causes and then build strong prevention strategies around them.

There are two immediate areas for CFOs to analyze denial data and target improvement efforts: unspecified ICD-10 codes and high-risk DRGs (diagnosis-related groups).

Unspecified ICD-10 codes

Unspecified cases will certainly be in the crosshairs after leniency for post-payment audits concludes on October 1, 2016. This could be problematic for those practices that have put clinical documentation and coding education for ICD-10 on the backburner. Payers could potentially begin denying all codes that do not comply with ICD-10 specificity—codes that had been previously accepted. This means that some providers could start seeing higher numbers of ICD-10-related denials and audits during the 4th quarter and into 2017.

To prevent denials due to unspecified codes, consider these five strategies:

1. Flag unspecified codes before submission, particularly for Medicare and Medicaid. Review cases with the denial prevention team.
2. Initiate regular communication between physicians, coders and CDI regarding unspecified cases.
3. Ensure ongoing coder assessments and training to determine if unspecified codes are due to faulty clinical documentation or coding errors.
4. Increase number of staff at times when denials due to unspecified codes are likely to increase.
5. Effectively use areas of expertise. Route specific denials and cases of unspecified coding to appropriate clinical specialists for internal, multidisciplinary education.

Review your coding processes now for targeted education and process improvements across all five steps listed above. When training, keep in mind the multidisciplinary team approach. By understanding each other's roles, we can maximize our knowledge and minimize duplication. For example, initial members of the ICD-10 implementation team may be perfect for the denial prevention team. Both are essential to a strong revenue cycle.

Brian Unell, vice president of revenue cycle at Piedmont Healthcare in Atlanta, Georgia exemplifies proactive denial prevention by pushing "real time documentation and coding improvements versus waiting for retrospective audits." The organization is highly invested in CDI to extract maximum value from their denial prevention efforts.

High-risk DRGs

Evaluate your organization's audit data to define the most common high-risk DRGs over the past six to twelve months. There should be a clear communication plan in place for denial prevention around these cases. Continually review data to proactively identify trends in upward or downward DRG shift. Work with the denial prevention team to determine who needs to know about problematic areas and when to notify them.

According to the American Hospital Association's (AHA) RACTrac Survey, incorrect MS-DRGs or other coding errors make up almost half of participating hospitals' complex denials (by dollar amount), while medically unnecessary inpatient stays (greater than or equal to two midnights) represent about a quarter of complex denials. Some of the most common DRG errors include

pneumonia, sepsis and renal failure. CFOs are advised to take the time now to establish solid denial prevention strategies based on the steps and focus areas above for high-risk DRGs.

Audits play key role in denial prevention

Finally, post-payment audits by RACs and other government and commercial payers play an important role in preventing denials. Efficiencies built into audit management processes produce key data and business insights for denial prevention. For example, savvy CFOs reduce administrative costs by coupling service-line experts with their audit departments.

Staff that manage recovery audits are brought together with clinical reviewers and representatives from HIM, coding compliance, care management, and medical staff to increase knowledge and reduce denials. These audit prevention teams focus on government-driven reviews and commercial contractual underpayments. They analyze the data together for a full picture of the denial impact.

As you move through this process, analyses will reveal, among many other things, where redundancies in denials and audits are occurring. Once these are identified and eliminated, workflows and processes can be streamlined to reduce costs and improve financial outcomes.

It is also beneficial during the training process to emphasize communication differences between payers and providers. This is key to preventing denials. Identify areas for improvement. Analyze trends and root causes of denials. And, when necessary, appeal appropriately!

About the Author:
As President of Primeau Consulting Group, Debra (Debi) Primeau has over 35 years of experience in Health Information Management and Health Information Technology as an Executive Consultant, IS Director, and HIM Director. Debi leads Primeau Consulting Group as HIM and HIT Practice Leader working with other HIM and HIT professionals in the industry to bring superior consulting services to the healthcare industry.