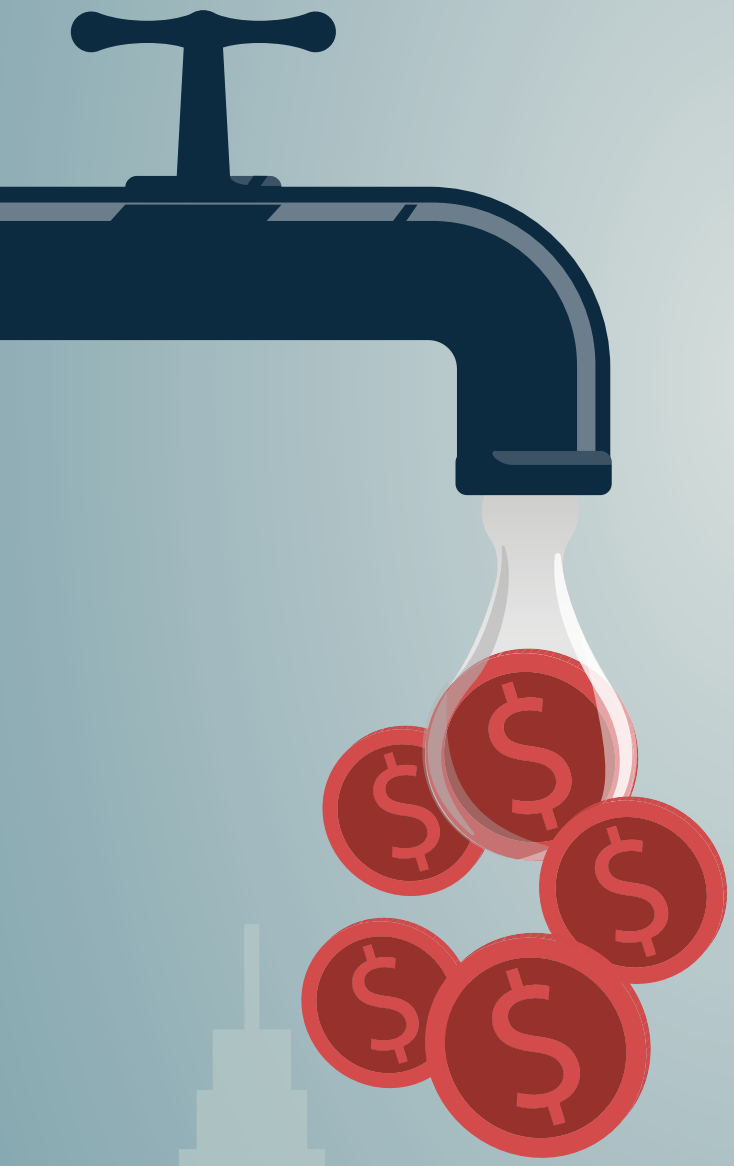
You've Been Denied and Underpaid!



Identify avoidable revenue shortfalls

By Don Billingsley, CRCR, and Landon Adkins, CIA

Effective denials management and underpayment functions are crucial to any healthcare organization's financial health and performance, particularly in the face of continuing reimbursement declines. Team collaboration across the entire organization, with support from internal audit, can significantly contribute to the success of a denials and underpayment management program.

Healthcare providers face numerous and sizeable challenges attempting to receive correct and adequate payment for services provided. Frequently, healthcare providers focus solely on managing denials and underpayments as they receive them rather than identifying opportunities to proactively avoid these revenue shortages in the first place. A denials and underpayment management program will both rebill for denied services and underpayments, and correct internal processes that resulted in the unnecessary shortfalls.

Challenges

Healthcare providers know that every process step counts and no room for error or inefficiency can be tolerated in securing reimbursement for services provided. However, revenue integrity can be challenging for providers due to numerous operational complexities. Patient clinical, charge and billing information are frequently managed across a variety of siloed departments. One department's deficiencies can adversely affect other departments' performance, as well as the overall integrity of a provider's revenue cycle.

Deficiencies and avoidable mistakes in key revenue cycle components undermine the effectiveness of a healthcare provider's revenue cycle. Providers tend to lose as much as five percent of net revenue due to a lack of effective processes for mitigating financial, regulatory and operational risks.

The revenue cycle is complex and comprised of numerous processes and players across a broad spectrum of activities. Providers are at risk for losing revenue at many points within the revenue cycle, especially in routine areas of operations where inefficiencies and a lack of communication between departments are common.

Internal auditors should consider evaluating revenue cycle processes against leading practices and identify needed improvements. By recognizing potential points of failure in the revenue cycle and focusing on high value areas, identified improvements can not only reduce financial leakage, but also improve patient satisfaction and compliance.

Strategy

Denials and underpayments management represents a significant opportunity to ensure revenue optimization. Specifically, processes for ensuring payment accuracy and correctly identifying and resolving denials and underpayments are critical to maintaining a healthy bottom line. The focus is not only the identification of payment inaccuracies, but also appealing denials and underpayments with the payers, watching data trends and reporting issues upstream to effect improvements in people, processes and technology.

Revenue cycle improvement assessments should include verification and analysis procedures for the items in Exhibit 1.

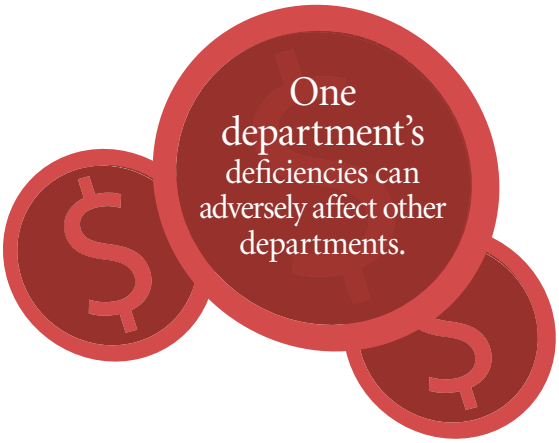


Exhibit 1 – Assessment focus

1. Resolve bill holds timely and comply with claim filing deadlines.
2. Reduce backlog and aggressively pursue resolution of denied claims.
3. Prioritize collection/appeals efforts to maximize yield based on volume, dollar value and probability of collecting.
4. Allocate duties and design procedures for appropriate cash posting activities.
5. Use contract management systems and tools effectively to ensure precision in identifying payment variances.
6. Appropriately classify, monitor and resolve all identified payment variances.
7. Adopt suitable write-off procedures to ensure timeliness of adjustments and accurate financial classification of contractual allowances, charity care and bad debt.
8. Produce and distribute to various stakeholders tracking, trending and data reports including reasons for denied claims, underpayments, payer rejects and internal system edit results.

Insurance companies deny paying benefits for reasons that are sometimes misleading or incorrect. But more times than not, denials are the result of breakdowns in revenue cycle processes. Claim denials generally affect five to nine percent of net revenue with approximately 50 percent of this amount lost each year. A significant amount of time, effort and cost is involved in reworking claims, sending appeals and collecting the remaining 50 percent of denials.

Providers with successful denials management tracking and classification processes should strive for total denials of less than three percent of revenue, with a denial-related bad debt write-off rate of less than one-half percent of revenue.

Explanation of benefits

Providers typically learn of an insurance claim denial via the explanation of benefits (EOB) remittance statement. The EOB usually contains an itemization of covered, noncovered and denied charges as well as a set of corresponding remittance codes.

Unfortunately, many providers rely on the payer as the source of truth rather than verifying that the denial reason is correct. Providers simply post the EOB information without further action or review. EOB explanations for denials should not be taken at face value nor as the final word.

In addition, clearinghouse and payer rejections as well as internal system edits are other sources of information that can benefit the denials assessment. Tracking and trending of rejections and edits can identify other revenue cycle process problems that can unnecessarily delay collection cycle time and diminish revenue realization. Some healthcare providers experience up to a 25 percent rejection rate from clearinghouses or payers.

Denials

The denials management process is generally perceived as simply a back-end financial function by many healthcare providers. However, revenue cycle leaders and internal auditors should view denials management as an end-to-end revenue cycle process needing continual business process re-engineering, system enhancements and training initiatives. Management must educate employees on denial issues and provide them with a broader understanding of the end-to-end revenue cycle process.

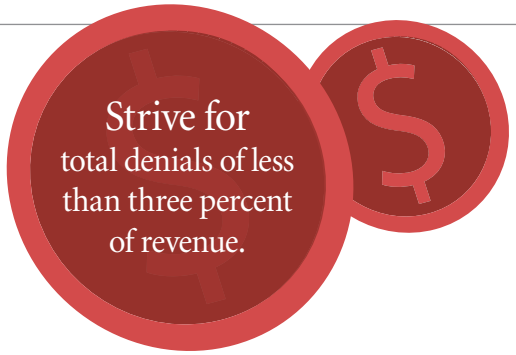
Just refiling a claim is not an effective solution to denials management issues. Providers should quantify, understand and identify the root cause to address potential opportunities to improve revenue. Most unrecoverable denials can be prevented with improved controls in upstream processes.

Where a payer denial is correct, and the responsibility lies with the provider's processes, a protocol should exist to communicate these denials to the upstream responsible parties. Ideally, the departments responsible for the denial should help resolve it.

Additionally, denials provide a wealth of information about your entire revenue cycle if you know where to look. Utilizing 835-format (explained later) remittance and payment data, quick analytics can be performed to diagnose problem areas, establish benchmarks and enhance your audit approach.

Underpayments

Managing underpayments is just as important as managing denials. Under-payments are transactions where the insurance company reimburses at a lower level than the agreed-upon rate per the contract. Underpayment amounts are many times as high as denial amounts, especially when a contract management system is not used to calculate expected reimbursement.



Like denials, underpayments are often recorded as a contractual adjustment. Complex payer contracts, lack of full visibility into contract stipulations, and the lack of contract management tools can result in substantial underpayments. A process must be in place to ensure payment is in accordance with contracts, as payers cannot be relied upon to do this for providers.

Best practice is to have a contract management system to monitor all payment variances outside of a defined threshold. Also, processes must ensure that contract data is complete and accurate when entered into the system. If that is not possible, analytics can routinely track, trend and audit payments to identify outliers for investigation and correction.

Systematically monitoring and resolving payment variances can result in a significant improvement to a provider's bottom line and provide the basis for enhancing integration and communication between departments.

Data diagnostics

Big data is a common buzzword in healthcare. Internal auditors recognize the pressing need to make use of data analytics to support and guide improvement initiatives. However, many are not sure where to begin in replacing their historical practice of sample testing a population of claims to identify process deficiencies and control gaps.

While sampling will continue to be a valuable audit procedure, internal auditors are expected to take advantage of data in a bigger way. With the powerful data analysis software currently available to internal auditors, and the expanded capabilities of Microsoft Access and Excel, the ability exists to analyze large amounts of data in ways previously unimaginable.

Internal auditors who can leverage data analytics to gain actionable, data-driven insights have a much greater potential to significantly enhance processes, productivity, total revenue and the patient experience with billing and collections. The data should allow the revenue cycle staff to prioritize their hands-on time to the highest value opportunities.

The challenge is not necessarily in the availability of data, but rather in how to use the vast amount of data that is available. Establishing an initial analytics process can feel overwhelming at the onset of development, but remember that change occurs one step at a time. An element of trial and error in pinpointing root cause issues through data analysis will always exist. Continually measuring, assessing and refining the data analytics process—and involving all key stakeholders—is important to success.

835 data format

The 835 data format is the electronic standard required by HIPAA for transmittal of EOB remittance codes. Payers are required to use the 835 format for claims processed electronically, which makes available a vast amount of valuable and structured raw data. The 835 data can be used to quickly perform a diagnostic assessment that points to opportunities across the revenue cycle. Once a data analysis structure has been established, you will have very quick and valuable insight into the following:

- Denials by service, charge, payer, physician provider and facility/clinic
- Revenue opportunities related to pricing, payment delays and potential underpayments
- High level benchmarking to conduct revenue cycle performance comparisons

From an analysis standpoint, the 835 data provides insight into all remittance codes, not just denials. Also, you can use the 835 data to test the effectiveness of posting, denial appeals and overturn processes.

If you rely solely on the denial reports provided by management to support your analysis, other valuable issues may be overlooked that are often hidden by what is commonly believed to be a contractual adjustment. A look into unexpected contractual adjustment variances may reveal a change in payer practice or an internal billing error that needs to be addressed.

Internal audit can also use the 835 data to test the integrity of management's monitoring and status reports from both a completeness and accuracy standpoint. Based on diagnostics derived from the 835 analytics, revenue cycle components may be identified with a high likelihood of control concerns. In addition, benchmarks should be established, continually monitored and compared to leading standards to identify key indicators in need of improvement.

In the past, denial audits were conducted through a manual review of a sample of claims traced to the EOB to ensure posting accuracy and correct denial identification. With the 835 format, account data can be tested against the entire 835 population over a selected period—typically a calendar year—in minimal time.

Sampling of select accounts should still occur to review the process in detail and to note any process issues, but 835 analytics can assist in identifying items with the greatest chance of revealing key issues. An effective review of your organization's denials management function often results in improvements that lead to an enhanced bottom line.

Summary

Providers must correctly identify its denials and underpayments and employ a process to research and challenge those denials or underpayments where appropriate. Revenue, compliance adherence and patient financial experience can be improved by effectively auditing the denials management and underpayments functions to identify root causes and proactively avoid them. Effective prevention often results in the organization spending much less time resolving issues and more time devoted to ensuring quality care is provided and revenue integrity is maintained. DI

Don Billingsley, CRCR, is a healthcare provider revenue cycle solutions leader and director with Protiviti. He has over 20 years of experience working with providers to assess and improve their revenue cycle operations and processes. You can reach Don at Don.Billingsley@protiviti.com and (214) 476-2933.

Landon Adkins, CIA, is a healthcare provider revenue cycle solutions leader and revenue integrity/data subject matter expert with Protiviti. He has over 12 years of experience in providing revenue cycle improvement, audit and compliance services. You can reach Landon at Landon.Adkins@protiviti.com and (469) 374-2489.