THE 7 MOST COMMON ROOT CAUSES FOR DENIALS AND DELAYED ACCOUNT RESOLUTION

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Payment delays and write-offs triggered by insurance denials represent a serious and growing financial concern for most hospitals and health systems. Despite concerted efforts across the industry, the average 350-bed hospital saw denial write-offs jump by 79% between 2011 and 2017, from $3.9 million to $7 million.[1]

$270 BILLION
U.S. hospital claims initially denied in 2016

All told, approximately 9% of $3 trillion in U.S. hospital claims were initially denied in 2016, while the administrative costs of reworking denials are now approaching $9 billion annually.[2] Even with this huge outlay, however, only about 35% of payer rejections are ever reworked and resubmitted.[3]

$9 BILLION
Spent annually reworking denials

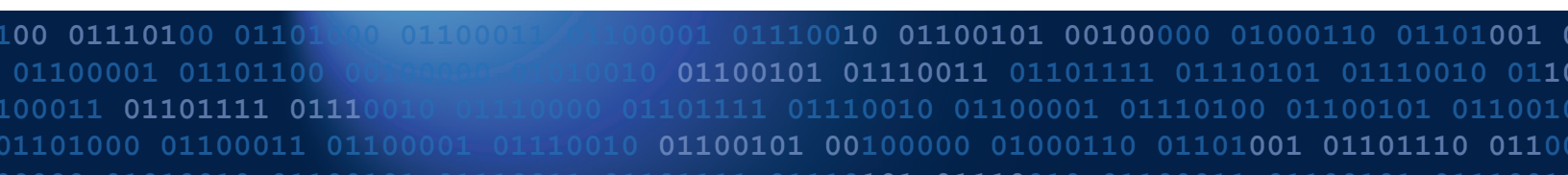
The struggle to stem chronic losses associated with rejected insurance claims reflects the complex nature of the reimbursement cycle. In a system that requires inputs from multiple points along the care continuum and is marked by frequent rule and policy changes, illuminating the primary causes of rejections and creating tools to resolve them can be enormously difficult.

That's why it can be cost-effective to partner with a qualified third-party that possesses the technology and expertise required to help hospitals isolate, identify and remediate issues that result in unresolved claims. ParaRev is a leading accounts receivable A/R resolution and recovery management firm with more than 20 years' experience helping hospitals address rejected and aging A/R.

Through a significant investment of time and resources, we've developed advanced intelligent automation capabilities that help us quickly understand how, why and where payment delays are occurring. Root causes can range from flawed internal processes and technology errors to insurance and clearinghouse mistakes. Regardless of the reason for the unresolved claim, it's important to remember that while only about two-thirds of denials are recoverable, 90% of them can be prevented.[4]

Hospital revenue management staff should therefore focus on developing a comprehensive knowledge base around the issues that trigger payment delays, either independently or in partnership with an A/R follow-up vendor. The hospital will then be positioned to systematically address the full spectrum of shortcomings that contribute to payment delays and write-offs.

The following list reflects the seven most common areas from which hospital claim delays typically arise – based on our clients' experiences nationwide – as well as general strategies for mitigating the problems.



Root Causes of Hospital Payment and Resolution Delays

Medical necessity

Pre-authorization

DRG downgrades

Experimental treatments

1. UTILIZATION

This category accounts for 25% of all denied charges among ParaRev clients and includes the clinical areas of medical necessity, pre-authorization, DRG downgrades and experimental treatments. Insurance companies will often challenge whether a specific treatment was medically required, whether the level of care provided corresponded to the underlying morbidity, or whether the length of stay was justified. Failure to obtain a necessary pre-authorization from the carrier for a specific treatment likewise can trigger a utilization denial. Still another common utilization denial involves challenges to the provision of emergency care. Experimental treatments, such as PET scans, 3D mammograms and computer-aided detections (CADs), also can result in denials.

Overcoming utilization denials requires that hospitals be well-versed in an insurance company's clinical policy bulletins, which describe what the carrier will and will not cover, what they consider to be medical necessity, and the treatments they deem to be experimental. At the same time, hospitals must be ready to promptly and consistently develop appeal narratives that make a strong medical case for the treatment provided. ParaRev relies on trained personnel, including RNs and registered health information technicians (RHITs), to write its appeals.

Denials relating to authorizations also can stem from something as simple as an authorization code not being included in the appropriate field of the insurance claim. By reviewing denial information with intelligent automation capabilities, these kinds of mistakes can be quickly isolated and addressed.

Errors or omissions

Eligibility verification

COB

2. COVERAGE

Unresolved claims due to coverage issues make up about 21% of denied charges for ParaRev clients. As the name implies, coverage denials involve real or perceived errors or omissions surrounding health plan coverage limits. One surprisingly frequent problem in this area involves the willingness of many hospitals to ignore patient eligibility rejections flagged by their eligibility verification system. Whether this tendency is the result of carelessness or reflects staff concerns about claim submission quotas, the net effect is that claims are rejected, and hospitals often are left with little recourse but to balance-bill the patient.

Issues surrounding the coordination of benefits (COB) or billing the appropriate insurer in cases where the patient has multiple coverages, represent another frequent source of denials. COB denials arise when a specific policy is no longer in effect or has been superseded by a replacement policy. One common example involves billing straight Medicare when a Medicare Advantage managed care policy is the primary coverage vehicle.

COB issues also can arise due to uncertainty surrounding worker's comp, auto or personal injury coverage. In these instances, resolution typically involves carefully tracing the policy guidelines as well as the nature of the illness or injury to determine which coverage is most appropriate.

3. CONTRACTUAL

Payment delays and rejections stemming from contractual issues make up the third-largest category of denied charges, at 17%. Contractual denials can involve a wide range of issues. But one of the most common entails payer underpayments for specific services like surgery, ED, lab and radiology, therapies and observation. Denials also can arise over misinterpretations regarding per diems, bundled payments for multiple procedures and carve-outs.

Payer underpayments

Per diems

Bundled payments

Carve-outs

Stop-loss limit

Inaccurate fee schedule

Incorrect APC applications

Root causes can be as simple as the inclusion on the claim of the wrong plan code (HMO vs. PPO), or as complex as a miscalculation of a stop-loss limit. Determining stop loss limits for inpatient claims frequently must be done by individuals, since the process involves multiple variables and equations that typically are too complex to resolve through contract management software-embedded rules.

The failure to maintain an accurate fee schedule by loading appropriate contract data into the hospital's contract management application is another common cause of denials. Constant attentiveness is therefore required to ensure that the contract management software is up-to-date. In addition, the careful application of ambulatory payment classifications (APCs) for outpatient services is important for calculating expected reimbursement. Site liability rejections involve denials stemming from the location where the service was performed. Because of division of financial responsibility agreements, conflicts can arise over whether the payer or site is ultimately responsible for covering the service.

In avoiding contractual-related denials, it is essential that hospital staff be cognizant of, and responsive to, the multiple deadlines associated with the filing and appeals process. These time limits can include deadlines for submission of medical records, corrected claims, appeals, and reconsiderations. Creating the capability to automatically track and flag deadlines in real-time therefore is critically important.

4. CODING AND BILLING

Coding and billing issues result in about 15% of all denied charges among ParaRev's client base. A common problem involves Reason Code 97 rejections triggered by the failure of the hospital team to turn on National Correct Coding Initiative (NCCI) edits. The edits basically provide a system of checks designed to prevent bundling/unbundling issues due to inappropriate CPT and HCPCS code usage, as well as inappropriate combinations of codes.

NCCI edits

Crosswalks

Demographic errors

Filing errors

Crosswalks, which map or translate specific codes from one code set to another, also are a frequent source of denials. Minimizing the issue usually requires rule creation or edits in software coding applications.

Demographic errors can include incorrect and/or outdated patient information collected by registration staff before or at the time of service and are a consistent source of denials. ParaRev relies on intelligent automation to categorize the type of rejection, which then allows the hospital to adjust its internal application to focus on the highest-priority demographic omission or mistake.

Finally, filing errors, including mistakes in value and occurrence codes and National Drug Code (NDC) application, account for a significant portion of code-related denials. The failure to designate the patient responsibility portion of the claim, for example, can cause the entire claim to be rejected.

Primary EOB

Crossovers

Missing records

Software bugs

5. SUBMISSION/RE-BILLING

Denials triggered by submission problems are responsible for about 15% of all denied charges. Failure to include the primary EOB, crossovers between supplemental and primary insurance and missing medical records are common rejection reasons. ParaRev's technology can quickly verify which missing documents are necessary for successful resubmission.

Problems also occur due to bugs in the hospital's electronic claims submission software or issues at the clearinghouse. Some clearinghouses, for example, are not properly equipped to efficiently process paper claims. As a result, the claim can often sit for an inordinate length of time. Continual communication with the clearinghouse is therefore important to ensure no reoccurring log jams or hidden delays.

Unapplied cash

Overpayment & refund

Unspecified fund

6. CASH POSTING

This category of issues produces about 4% of denied charges and frequently involves determining the appropriate allocation of unapplied cash. For example, assessing the differences between recoupments, or refunds for overpayments, and offsets, which involve allocating unspecified funds to existing claims, requires careful analysis of policy language and covered services previously paid for.

Payment delays

7. PROCESS DELAYS

Process issues account for 3% of denied charges and usually involve payers taking an excessive amount of time to process a claim for reasons unrelated to the claim itself. It is therefore important for hospitals to identify and isolate payment delay patterns involving specific payers. This enables prompt follow-up with the carrier to ensure payments are made in accordance with the terms of the existing contract.

A Working Partnership

ParaRev delivers a wide array of capabilities designed to quickly identify the causes of denials, including those involving high-volume, low-dollar value claims. Many vendors ignore or discount these types of denials due to either technology limitations or a desire to focus on high-dollar claims and the greater renumeration that comes with resolving them. ParaRev also provides clients with ongoing consultation and process engineering recommendations to help prevent denials from occurring in the first place.

For truly effective denial remediation and prevention, however, it is important for hospitals to understand that aligning with an A/R follow-up management vendor requires ongoing collaboration and communication between the parties. That means essentially treating the vendor as an extension of the hospital's internal business office. Sharing desk procedures and process flows, collaborating about known payer issues, providing access to managed care contracts, EDI files and EMR, clearinghouse, correspondence and imaging systems all are necessary to maximize the return on any A/R management firm engagement.

Healing an Open Wound

For many hospitals, denials are a festering financial wound that refuses to heal. Some organizations have resigned themselves to living with the write-offs associated with denials, but this approach is short-sighted in today's increasing challenging economic environment. With an average operating margin of just 2.7%, hospitals can't afford not to follow up on every dollar owed them for service.[5]

That's why hospitals should consider partnering with a qualified third-party to develop and implement a comprehensive A/R resolution strategy. By reducing the incidence of denials and resolving those that do occur more quickly, cash flow is increased, write-offs are reduced, and administrative staff time can be used more efficiently. Contact ParaRev today to learn more about the many ways we can help improve your accounts receivable.

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[1] Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018
[2] Philip Betbeze, "Claims Appeals Cost Hospitals Up to $8.6B Annually," HealthLeaders, June 26, 2017
[3] Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA, July 7, 2015
[4] Morgan Haines, "An ounce of prevention pays off: 90% of denials are preventable," Advisory Board, Dec. 11, 2014
[5] Ayla Ellison, Jessica Kim Cohen, "224 hospital benchmarks," Becker's Hospital Review, June 25, 2018

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ParaRev transforms accounts receivable follow-up by harnessing intelligent automation to help hospitals and health systems accelerate cash flow and improve operating margins by resolving insurance claims quickly and effectively.

For more information, visit: www.pararevenue.com
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