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5 Denial Management Metrics that can be managed effortlessly using the right tools

A study conducted by Modern Healthcare states that most healthcare organizations lose 8-10% of their net revenue due to denials. Constant regulatory changes and growing scrutiny over medical billing practices have made denials commonplace.

The initial denial rate of most hospitals is a startling 7-10%. Handling denials effectively can be the difference between operating at a profit and staying in the black.

You either throw up your hands in frustration and let revenue slip away or take measures to slay the denial monster before it spreads its tentacles too far. That is the arithmetic of the healthcare industry.

This whitepaper outlines vital strategies and tools to monitor and manage claim denials. Tracking the right metrics and utilizing smart tools helps healthcare systems to separate myths from facts. This whitepaper shows you how to achieve positive outcomes by leveraging on technology and machine intelligence.

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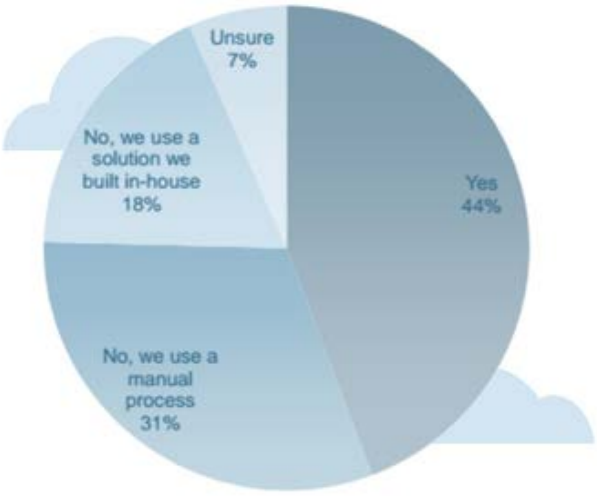

Behind the Curve

A recent survey conducted by HIMSS Analytics states that half the hospitals it surveyed were not using denial management tools provided by revenue cycle vendors. 31% of hospitals still use manual processes and 18% of them use homegrown tools. This survey reflects the bleak reality that despite several wake-up calls most healthcare organizations are yet to take proactive measures to address and prevent denials.

Steps to eliminate recurring denials and drive up continual process improvements

Before taking the first step towards denial prevention and deploying tools medical practices need to realize that not all denials are equal. Determining the appropriate denial benchmark to aim for is a major challenge. To increase revenue healthcare organizations should differentiate between hard and soft denials. Because reducing denial rate alone will not increase cash flow. As some denials denote lost revenue opportunities while some indicate misclassified insurance. Not all denials create a negative impact on a practice's revenue stream. In fact certain claims have to be denied by primary payers in order to be paid by secondary insurance payers.

Unpreventable and misclassified denials:

- Denials arising out of insurance coverage issues
- Claims that are denied by the payer's electronic data interchange system
- Demand denials when a Medicare beneficiary has signed an ABN

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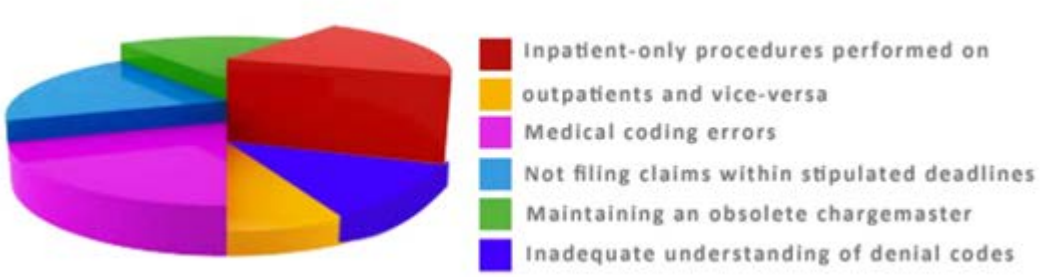
Preventable Denials

These are the denials providers should be focusing on to prevent revenue leakage.



- Inpatient-only procedures performed on outpatients and vice-versa
- Medical coding errors
- Not filing claims within stipulated deadlines
- Maintaining an obsolete charge master
- Inadequate understanding of denial codes

It is vital to identify and categorize denials and understand their full impact, to predict and drive outcomes. And this is where most denial management tools fail. They provide insights into number of denials, denials categorized by payer and comparison charts. It is a solid baseline. But not enough…A denial management tool should do more than just present generic claim denial information. It should go beyond the basics and illuminate areas of your denial management process and offer critical business intelligence that will stop denials before they start diminishing your collections.

5 Important denial management metrics that your tool should track…

- Percentage of soft and hard denials
- Rate of partially paid claims
- Coding related denials percentage
- Insurer-specific denial reports
- Top denial reason codes

1 Percentage of hard and soft denials

Not all denials will have a severe impact on your bottom line. Hard denials are denials that result in written-off revenue. A healthcare organization should resubmit the entire claim to the insurer.

The most common denominators for hard denials are uncovered services, incorrect bundling/unbundling of claims, missing prior authorization information and delayed filing of claims.

Soft denials on the other hand are just a temporary setback to the revenue cycle and have the potential to be paid in full after follow-up by the provider's office. Analysis and follow up.

Segregating denials in these two categories is the first step towards tackling denied claims. It will help organizations to prioritize and allocate resources based on the nature of the denied claim. A denial management tool should be able to segregate denials into these 2 categories for easy

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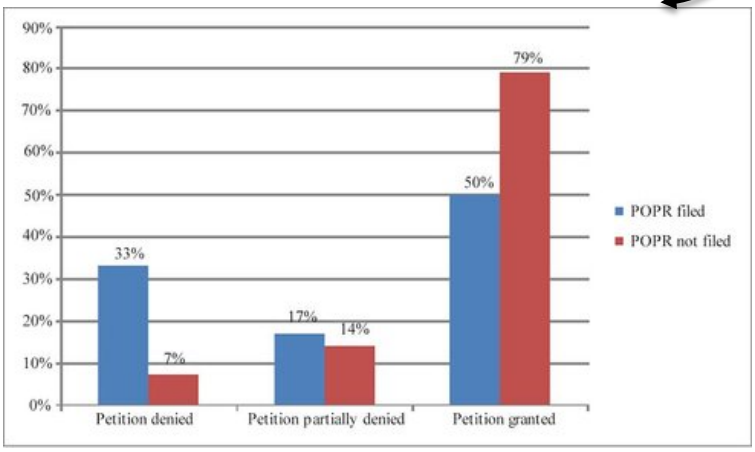
2 Rate of partially denied claims

A study by MGMA states that insurance companies underpay providers by 7% to 11% on an average. Partially paid claims, if gone unnoticed can snowball into major revenue drainers. The number of underpaid claims against the total number of claims submitted will give medical practices an idea of the percentage of pending revenue vs. unpaid revenue. A denial analysis tool that compares payments against the contracted fee-schedule will enable practices to spot and eliminate underpayments. It is manually impossible to pore over hundreds of claims to identify partial-pays. And that is why it is vital that a denial management tool bubbles up underpaid claims that require attention.



3 Coding related denials percentage

According to a finding by CMS 0.9% of claims, were rejected due to improper ICD-10 codes and 0.11% of claims were denied because of inaccurate ICD-9 codes. The medical coding process forms the backbone of the revenue cycle. Incorrect coding practices will not only lead to revenue loss but also compliance issues. So coding related denial metrics should be tracked and monitored closely.

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4 Insurer specific denial reports

There are some insurance companies that deny claims more often than the rest. An insurer-specific denial report helps medical practices to identify payers who deny claims regularly and take corrective measures. Such as analyzing and updating contracts, studying denial codes to prevent future denials and in some instances stop working with an insurer all-together.

5 Top denial reason codes

Analyzing reason and remark codes is mission critical to zero down on denials. When denials are categorized according to denial codes it will enable healthcare organizations to spot and track denial patterns. Most denials share a common denominator. By studying denial codes, practices can identify the common factors behind denied claims such as eligibility errors, missing DOS, lack of pre-certification, insufficient documentation, delayed filing of claims, coding errors etc…

A full-fledged denial management and prevention tool should be able to track these 5 major metrics to safeguard your organization against financial instability and compliance issues.

Top 10 Medicare Part B Claim Denials

	Denial Category	CARC/RARC Messages
1.	Duplicate Claim/Services	18 N347 M86
2.	Medical Necessity	50 N102 N115 N109
3.	Medicare Advantage Plans	109
4.	Provider Eligibility	B7 172 38
5.	National Correct Coding Initiative	M80 B15
6.	Screening/Routine	49 M37
7.	Non-Covered Services	204 N386 N103 N113
8.	Patient Supplies	M15
9.	Non-Covered Charge	N126 N425
10.	Time Limit	29

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About Us

AnesthesiaBillingBridge is a revenue cycle management company with footprints all across the country. We help healthcare organizations maintain a positive cash-flow, stay compliant and reduce cost to collect. Our tools and applications will enable medical practices to take quick decisions about their revenue cycle operations.

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