TAKE ME OUT TO THE Ballgame

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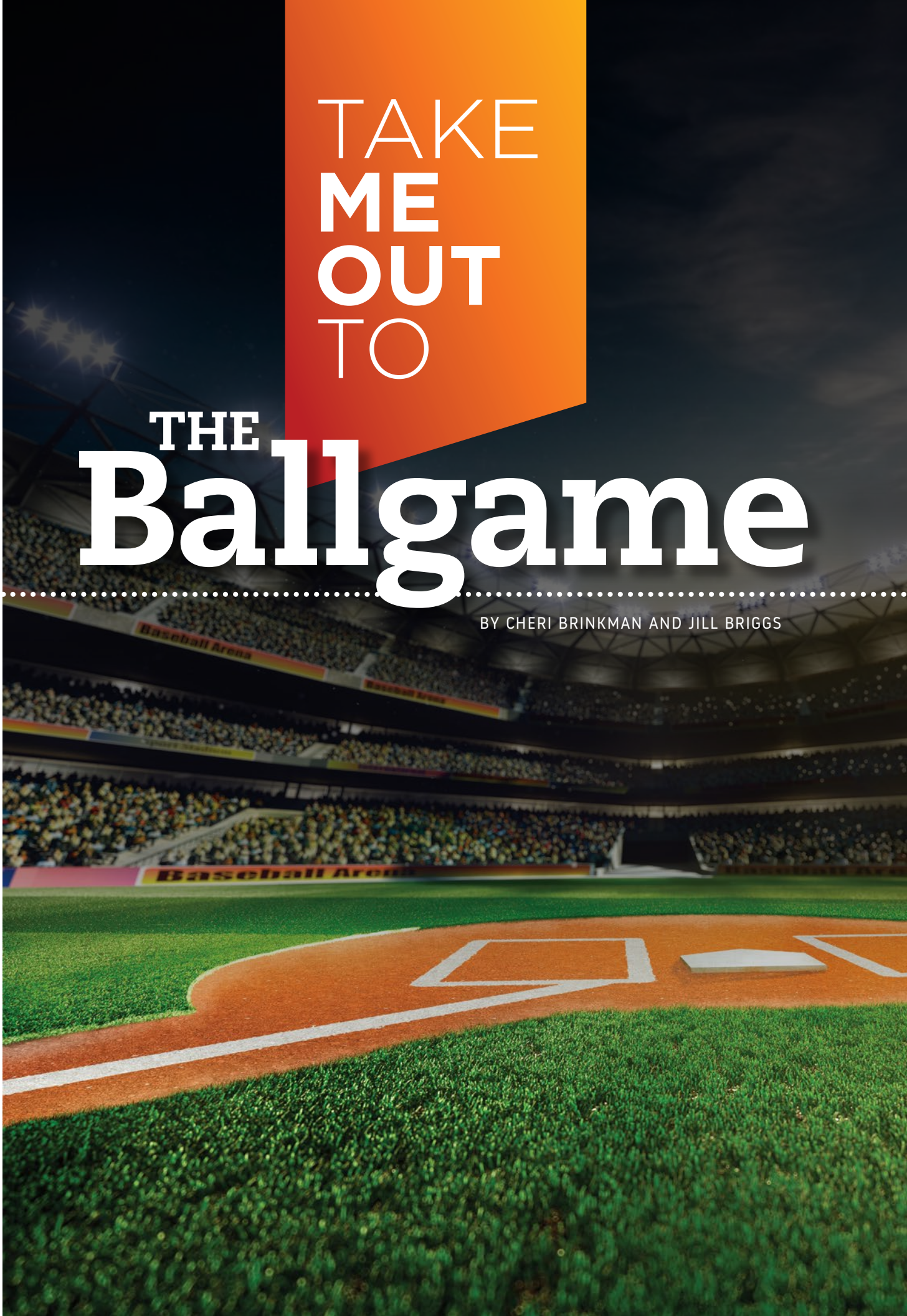

HOW TO ROUND THE BASES ON PAYOR DENIALS AND CREATE A CHAMPIONSHIP PROCESS.

Benjamin Franklin said it best with his famous quote "…nothing can be said to be certain, except death and taxes." For those of us in the medical billing industry, denied claims should be added to that list. Any physician providing care to patients is most assuredly receiving denials. To create a winning process, the practice must be willing to get into the game and strategically work with denied claims. According to an Advisory Board study, "About two-thirds of denials are recoverable, but almost all (90 percent) of them are preventable."[1] The strategy of how to handle those denied claims can be compared to that of a game of baseball.

Let's explore America's pastime and see what it can teach us about how to swing for the fences and come out with championship results. Step up to the plate ready to play and be prepared for anything the insurance companies throw.

Pop fly—instant outs and how to avoid them

There are several areas that will cause denials every time. Watch for these common denials that leave you with little recourse. These pop flies can be instant outs if you aren't prepared.

Timely filing—The first line of defense is to know your contractual obligations. Routinely review your contracts and amendments for the timely filing limitations. As you do, consider renegotiating any that leave you with less than six months from the date of service to submit a claim. This allows you ample time in the event of a delayed file, late addendum, or other unforeseen circumstance. While reviewing the contract, determine the time frame for appeals as well. It is imperative to ensure that all follow up is being done within the proper timeframe. Anything less is an instant out and causes the practice to lose out on potential revenue.

Don't be deterred by a timely filing denial. Most payors will consider appeals for claims denied as timely with the proper documentation. If there was a legitimate reason for the delayed claim, gather the documentation and prepare an appeal letter. Swing for the fences and plead the case to overturn the initial decision.

Enrollment—A healthy practice will see changes in enrollment from time to time. New physicians join the group, founding partners may retire, new contracts at different facilities, and more can lead to necessary updates to the group's enrollment records with payors. Invest the time in spring training to review the regulations by payor and follow the necessary processes when making updates to the group. Claims will be denied when the proper procedures are not followed.

Once the updates have been submitted, follow through on the swing. Don't submit and forget. All changes must have thorough follow up. Ensure that the updates were received and implemented properly at the payor. Any missteps can result in costly denials. Once the first claims are submitted, follow through to ensure proper adjudication.

Not eligible at the time of service—This eligibility denial is perhaps one of the most common. For patient facing practices, the best strategy to overcome eligibility denials is to implement a process to verify eligibility before the patient is treated. Good intentioned patients can still inadvertently provide you with an old insurance card. A process to check the eligibility of those policies is essential to keeping these claims on the bases. Once the patient has left your office and the claim is denied, it becomes harder to obtain the proper information.

For the non-patient facing providers—scrub those demos! Before resigning yourself to a denied claim and being counted out, implement a process to review the data before the claim is submitted. There are several easy signs to key you in on a potential pop fly. For example, institute a process to verify any patient over the age of 65 that does not present with Medicare. This is a quick way to keep you on base for the inning.

Insurance curveballs—unexpected errors

Close your eyes and imagine yourself stepping up to the plate. Every claim filed is another chance to hold the bat high and swing hard to make contact. One of the most challenging skills for novice players to learn is to watch the pitch and keep an eye out for curveballs. In a perfect world, all pitches and claim adjudications are created equally. In reality, the payor can throw any number of unexpected pitches to the claim. Below are a few examples and pointers to help as you study the game film.

Non-ANSI codes—With the implementation of HIPAA, all payors became standardized by utilizing the same ANSI denial codes, right? Wrong, for anyone working the backend of the RCM process, it's common knowledge that it simply isn't always true. While most payors are doing a great job at adhering, there are still those that create their own generic codes and respond via traditional hard copy Explanation of Benefits creating an unexpected hiccup.

Create a process to fit these non-ANSI codes into the standardized bucket. This will allow your team to implement a strategy to handle all like denials the same. It also provides greater options when it comes time to report on your denial trends.

Medical records reviews—Additional requests for documentation are a common pitch used by many payors. Requests can encompass many different aspects of the medical record and may be requested directly from your office or the referring physician. Be sure to read all requests carefully and timely. Pull all requested documentation and submit to the payor as requested by the deadline given. A late swing on a ball can result in costly foul balls for what is otherwise an easy base hit.

COB updates—Just as insurances throw curve balls to the providers, patients also receive bad pitches from time to time. The most common cause for payors to review information from the patient is to determine coordination of benefits status. This may be due to dual coverage, a parent/child relationship or even liability carriers. Carefully study the pitch to determine when the request is made to the patient. Consider contacting the patient or

sending a statement to motivate them to respond in a timely manner.

Designated hitter—tools to knock it out of the park

Just as you wouldn't expect a batter to step up to the plate without a bat and helmet, you shouldn't expect your team to approach denials without the proper tools. How can you equip and strengthen your team to hit more home runs? Knowing the proper place for tools and individuals using them can help ensure your team's success.

Facility accesses—Many non-patient facing providers don't see the patient first hand. One of the best tools for your team to utilize is access to the facility system. This allows your team the ability to pull copies of the original orders, medical records and verify copies of the insurance cards. The opportunity to see this information first hand when processing denials is crucial.

Websites—Take the time to familiarize your team with the websites and functionality of payor websites. Choosing the tools that allow for online claim corrections and appeals can save your team time and shorten the turnaround for receipts. Become experts at your Medicare Administrators website, Availity and Navinet – both include access to many major national and regional payors. Don't forget to check in with any regional payors for their websites that might not be included otherwise. Many clearinghouses have the ability to adjust and resubmit claim corrections as well. Check with your vendor to learn what options are available to you. These tools can reduce the time spent on the phone for follow up.

Template letters—Review your denials to see what procedures are denied frequently for the same reasons. Create basic template letters to help streamline your appeal process. This will allow the denials team to update the patient-specific information and keeps verbiage consistent. Some great examples of this method are bilateral or repeated procedures. These procedures are denoted on the claim with a modifier. A common denial for these procedures is duplicate charge. Often, this is because a modifier wasn't recognized by the payor when processing. Simple verbiage on the appeal can be used for successful resolution. Create verbiage that can be used in a templated appeal letter or copied into payor specific appeal forms as needed.

Software to route denials—Evaluate what options are at your fingertips to organize your denied claims. Some clearinghouses and practice management systems have denial management tools included. If yours does not, there are also several third-party options to consider. Find a method that works for your practice to route denials to the most appropriate person to work. Send in a designated hitter – or coding expert to review medical necessity denials while a billing expert reviews the record requests. Keep your team in the proper positions on the field to maximize your results.

Persistence pays—The most critical tool for any denial team to possess is persistence. Instill in your team the desire to legitimately win. Employ those to assist your process that will fight for every dollar compliantly and diligently. The competitive nature of these team players will help you maintain a winning record and maximize your revenue.

Relief pitchers—quality assurance

A strong baseball team has depth in the bullpen allowing other pitchers to relieve the starters. Your denial team is only as strong as the support behind it. The value of quality assurance cannot be overlooked as it relates to the denial process.

Software claim edits—The best tool for denials is prevention. Research and implement a process to proactively check claims before submission for published edits. Many options are available for claim scrubbing edits to review CCI edits, LCD, and NCD policies. Check what options your practice management software, clearinghouse, or other third-party vendors can offer to help you implement these tools to proactively increase the quality of your claims and in turn reduce your denials.

Automation—Ronald Reagan often said, "Trust but verify." Validate that any automation implemented in your process is working as intended on a routine basis. As payors change rules, so must your responses. Review these processes to ensure that no routine write-offs are occurring. Ensure that denials entering the system are routing to the proper teams and not being overlooked. A pitching machine is a great tool but without proper maintenance, it may throw more balls than strikes. Don't underestimate the power of the human touch.

QA reviews—Investment in quality assurance reviews and continued training for your denial team will help light up the scoreboard. Routinely review the appeals sent. Monitor the success of these appeals. A few suggested areas to start monitoring are: What verbiage is successful? What documentation was provided for successful appeals? Were they online or paper? Did we use the proper form? Was it completed accurately? Did we notate our internal account properly? Use these areas to find ways to improve your process and provide training to your team members.

Coaching strategies—trending and feedback

Every coach has a different strategy to give his/her team the advantage. From t-ball, little league, and all the way to the MLB there are countless approaches to each aspect of the game. Denial strategy has just as many options. Highlighted in this section are a few popular methods, trend processes, and opportunities for feedback.

WORKFLOW METHODS:

Date in-date out method—The classic method of first in, first out is popular when strategizing workflow for denials and for good reason. A runner on first base can't go around the one on third to score. This method ensures that the oldest by date of denial received is worked first. By employing this strategy, you keep appeal time limits in check.

Work high dollars more frequently—While using the date of denial is a good strategy, there are benefits to reviewing the claims with the highest dollars early. This maximizes your ability to increase the revenue by ensuring the claims with highest balances and/or best reimbursements are processed a bit ahead of the others. Stack your lineup to place the best hitter in cleanup to increase the odds of a higher score.

Payor specialization—Many experienced team members find it beneficial to specialize in payors. This allows team members to focus their attention on the forms, medical policies and guidelines of one payor instead of all. Consider if it would advantageous to your practice to assign a specialized team member for large payor groups such as Medicare, Medicaid, Blues, United Healthcare, and the like.

TRENDS:

Denial reason trends—Implement a process to trend the reasons codes behind the denials. This becomes easier as you can track each incoming denial reason into similar ANSI buckets. This tracking will help route all the reasons associated with diagnosis or eligibility together. Using this tracking method gives you the ability to focus more attention on the controllable causes.

CPT/ICD10 trends—Strategically monitor the codes receiving denials. Ask yourself if a particular CPT or ICD-10 code is being denied more than others. If so, do some research. Pull the stats and determine if there are any common denominators. Is it ordered by the same physician? Is it performed at the facility? What was initially ordered? These are all areas that can open up the discussion to provide feedback and change if needed.

Create process changes—The most important element for trending to the ability to nimbly make changes when an opportunity is found. Denial management is an ever-changing game. To keep up, we must be able to identify trends and look for windows of opportunity to change our processes when necessary. Being proactive in response to the trends will help you stop denials before they start.

FEEDBACK OPPORTUNITIES:

As you take the field to face the denial process, use all the tools and trends available to you to determine where feedback is beneficial to prevent future denials. Just a few of the areas to consider for routine feedback and education are listed below.

Coders and billers—Consider monitoring through trends and quality assurance for the performance of the individuals coding and processing the claims. Provide continuing education to keep these team members at peak performance.

Attending and referring physicians—As the specialists providing and dictating the services or placing the orders, they need to be kept up to date on items within their control. If a procedure is never covered for a diagnosis code, he/she may be able to provide documentation of the medical necessity or order an alternate exam. Perhaps an attending physician is inadvertently leaving a few words out of the dictation that could compliantly yield better results. Providing routine feedback to the physicians can help the entire team work together to round the bases for a score.

Scorecard—keeping stats for the GM

As you approach the seventh inning stretch of establishing your denial process, take time to review the team stats. Without goals, it's impossible to score. Set your process, take aim for a championship run and with diligence, you can find yourself in the World Series. If you don't measure it, you can't improve it. Below are the top six areas to start measuring to see if your team has what it takes to make a championship run.

Top denial reasons—Routinely review the list of your top 10 denial reasons. This helps you identify which of these to focus efforts to prevent. Remember the goal is to stop the denial before it starts and maximize revenue.

Payor trends—Track what payors are returning the highest denial rate. Explore options to see if there are contractual issues, medical policies or other claim requirements. You may be able to quickly resolve several denials at once by trending like issues.

Modality/CPT/diagnosis trends—Coding trends can reveal opportunities to review medical policy, coding guidelines, and regulatory requirements. Monitor payor websites and newsletters for updates to policies and guidelines. Stay active in authoritative industry organizations such as the AAPC (American Association of Professional Coders) to keep the skills of your team sharp.

Denial rate—A telltale sign of a good billing process is the denial rate. Keep a pulse on what percentage of your claims are denied. This can be indicative of deeper issues with the process. Any denial rate over 10 percent should be investigated.

Denial recovery rate—Once the denial rate has been established, the next step in ensuring your scorecard continues to improve is the resolution rate. If the denials are not being worked or not worked timely, hard-earned revenue is being lost. A great measurement is to track the amount recovered by denied RVU and compare to the practice overall receipt per RVU. The amounts should be similar if a healthy process is in place.

Productivity benchmarks—A good baseball coach knows how each member of the team is performing. Keeping stats on your denial team will help us identify which position each player takes. Ensure that everyone is producing the results desired.

Light up the scoreboard and claim your prize

Which prize will your denial process yield, the World Series trophy or a Cracker Jack prize? The choice is yours. Focus on the elements in your control. Take the field with the knowledge to watch for curveballs, call backup in from the dugout, and swing for the fences. The first step to improving your process and results is to step on the field. An effective denial management process is a sign of a healthy practice. With the right tools, your team will be championship caliber with a record of proven success.

REFERENCES

1. https://www.advisory.com/research/financial-leadership-council/at-the-margins/2014/12/denials-management

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