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Payment issues

Taking the Offensive Against Claims Denials

By Amy Buttell Crane

Alert staff and the right technology can ensure that hospitals get the payments they deserve

Claims denials are a fact of life, and the constantly changing nature of coding, claims forms and new technologies means that a permanent fix isn't in the cards. Many health systems, however, are implementing solutions that not only lower their percentage of denials, but also improve their cash flow and bottom line.

In many cases, it's a two-pronged approach: fixing broken processes on the front end that lead to denials and aggressively working the denials that come in on the back end.

On the front end, a variety of seemingly unrelated steps in the process—including payer contract negotiations, admitting, charge capture and billing—all contribute to the potential success or failure of getting a claim paid. By promoting cross-department cooperation that attacks the breakdowns in various steps in the claims life cycle, denial percentages will begin to fall.

"Educating staff across the board is key," says Phillip Brooks, director of patient financial services at Summa Health Systems in Ohio. "It's like an orchestra: When everyone is working together, it sounds great; but when one part isn't working right, you can hear it. So the challenge is to figure out what happened and fix the process."

On the back end, you need a clear understanding of where your denials are coming from in terms of both the reason for them and the payer involved. That means creating some type of denial management database.

"We've seen the denials problem increasing over the years, not really by leaps and bounds but more incrementally," says Barry Franklin, chief financial officer of Parma (Ohio) Community General Hospital. "It's always a problem—when payments are short by \$100 here and a \$1,000 there, pretty soon you're talking about real money."

The Scope of the Problem

A study by PNC Financial Solutions released in March found that 7 percent of all claims submitted were never paid and 20 percent of all claims submitted are delayed or denied. America's Health Insurance Plans, a trade association, sponsored a study in 2006 that pegs the cost to process a clean electronic claim at 85 cents and the same paper claim at \$1.58. Claims reviewed or delayed cost insurers \$2.05 on average to process. The added expenses contribute to the nation's burgeoning health care costs and will at some point get passed on to providers and patients.

While 86 percent of all claims are processed within 30 days of receipt, the remaining 14 percent are delayed for a variety of reasons, including:

- Submission of duplicate claims
- Lack of complete information/data
- Coverage or out-of-network issues
- Coordination of benefits.

Definition of a Clean Claim

Much of the problem can be blamed on the fact that there is no standard definition of what a clean claim exactly is. “There is no consistency with the claims submissions process,” says Suzanne Lestina, technical manager, patient financial services/revenue cycle at the Healthcare Financial Management Association. “Each payer has their own requirements and their own definition of a clean claim, and basically the providers are at the mercy of the payers.”

Sharita Lane, vice president of reimbursement and economic analysis at the California Hospital Association, agrees, saying, “Denials continue to be a problem for our member hospitals and this has a lot to do with the changing requirements put into place by the health plans. Frequently, they change the terms in the middle of the contract, leaving health systems chasing a constantly moving target.”

H&HN attempted to get comments from a number of health insurers, but repeated requests went unanswered.

The Contract: The First Step

The contract between your health system and a managed care company governs every aspect of the claims process. A good contract can keep your denials down to a manageable level; a bad contract leaves you open to more denials and audits.

“Taking the time to negotiate a good contract and making sure that any provisions like claims auditing are reciprocal and time-limited is really important,” says Stephanie Alexander, an attorney with Tripp Scott in Fort Lauderdale, Fla. “Getting staff involved from various departments such as audit and [accounts receivable] is vital so that you’re aware of problems that you are having with a particular provider and can use that information to not only negotiate a better contract going forward but also to get paid what you are currently owed.”

Poorly negotiated contracts can hamstring staff, making it extremely difficult or impossible to get claims paid.

“I’ve seen contracts where the billing person has to get the manufacturer’s invoice for a particular implant to submit along with the claim and something like that creates a lot more work for the staff,” says Sherrie Wyatt, a nurse and owner of CompMed Analysis, a Stowe, Ohio, consulting firm that specializes in claims denials.

More Effective Admitting

The claims process begins with the preadmissions and admission process. Of course, front-line staff need to be trained to make sure the right forms are filled out, but they also need to be able to verify that the patient’s insurance information is correct, collect any co-pays due and check that any necessary pre-authorization forms from physicians and insurances are on file. Technology helps.

“With an online interface between the hospital and the insurer, the admitting staff can check on eligibility for a particular patient during the admitting process,” says Peggy Denness, director of user advocacy for NaviMedix, a Cambridge, Mass., technology firm.

“Many flat-out denials are where the insurer states that they aren’t the payer for this claim,” says Mark Nikolas, director of partner solutions for Accuro Healthcare Solutions, a Dallas technology firm focused on revenue cycle management. “It happens all the time—many employees aren’t even sure what insurance they carry and may present the wrong card in admitting because employers are changing insurers frequently in a effort to control costs.” Front-line staff need to check if there are primary and secondary payers and whether the patient’s insurer is even on the hook for the claim—perhaps the admission is due to an injury covered by workers’ compensation or was sustained in a car accident, in which case auto insurance would kick in. “Figuring out who is supposed to pay can be a real hornet’s nest,” Nikolas says.

Charge Capture & Coding

Correctly documenting the services and procedures a patient receives during a stay or even in a visit to the emergency room—known as charge capture—is a vitally important step in the process. For example, if a clinician documents a medication the patient receives but forgets to record how those meds were delivered, the insurer won't pay for the delivery, just the medication. It's unlikely that the medication was infused "immaculately" as Wyatt facetiously terms it; nevertheless, without the charge capture, you won't get paid.

Once the services are captured correctly, medical staff must sign off on charts and correctly code the claims. Coding requirements change constantly, and staff must stay alert and current, says Kathy Johnson, director of coding services for Care Communications, Chicago. For example, hospitals will soon be required to specify whether a particular infection or ailment was present when the patient was admitted or was acquired during his or her hospital stay.

"There's lots of speculating on what will be done with this information—will insurers use it as a reason to deny payments for infections acquired during admission? And how will staff be trained to make this determination?" Johnson says.

Identifying & Fighting Denials

Once claims are denied, staff must track them and communicate problems to other departments so a fix can be found.

"In order to get a handle on your denials, you have to define the problem," says Brian Robertson, senior vice president of MedeFinance Inc., an Emeryville, Calif., technology firm focused on the revenue cycle. "This includes not only figuring out what types of denials you are seeing, but also looking at which payers those denials are coming from."

To this end, Robertson advocates classifying denials as pending, won or lost, as follows:

- Overturn win-loss experience by payer, function area and reason code.
- Successful denial overturn by payer, function area and reason code.
- Unsuccessful denial overturn also by payer, function area and reason code.

Technology and training are important in denials management for both CFOs and front-line staff. "I used to spend one or two days a week on the phone with insurers over denials," says Becky McCaig, an accounts receivable clerk at 238-bed Weirton (W.Va.) Medical Center.

Now, using a NaviMedix system, she spends less than half a day a week on the phone and can work denials by requesting investigations through the medical center's online system.

Premature write-offs are a major area where hospitals can improve their denials, and that's where training can have a big impact. "Many times, a cash poster will write off the remaining balance of a claim that is partially paid," Wyatt says. "Then, no one knows why the whole amount of the claim wasn't collected because it was written off. I recommend that hospitals limit who has the authority to write off accounts [and that person should] go through them, analyze them and make an effort to collect on those partial denials that can be recovered."

Contracts with insurers often set time limits under which a claim can be paid—if staff doesn't keep on top of denials, a facility risks never collecting the money.

Staff must also keep up with new technologies that require third-party authorizations, such as certain radiology procedures. Independent review organizations are hired to pre-authorize certain medical procedures.

The Bottom Line

For Kelly Murray, patient accounting team lead in the billing office at Logan (W.Va.) Regional Medical Center, dealing with the various aspects of denial management is getting more challenging. “We have a couple of insurers that are denying us a lot based on pre-existing conditions and we’re seeing more problems with coordination of benefits,” she says. “Times are changing and patients are becoming more responsible for understanding their coverage and even paying their own bills, so we are spending more time educating patients.”

Brooks says that the many “disparate systems used by providers and payers along with too many rules” means that hospitals and their staffs have to take responsibility for their part in the system, but can’t fix the whole problem.

Robertson sees more initiatives between payers and providers to cooperate at a facility level, but believes a broader effort is the real answer. “It’s an arms race right now between providers and payers and there is an unfortunate ‘us’ versus ‘them’ mentality,” he says. “There are some areas where progress is being made, but I think it will be a few more years before we see some real progress.”—**Amy Buttell Crane** is a writer based in Erie, Pa.

Savings: Reducing Overhead

Nearly 30 cents of every health care dollar goes to administrative costs, according to a March study by PNC Financial Services. Hospitals responding to the PNC survey said one in five claims is delayed or denied by an insurer; 96 percent must be resubmitted at least once. When asked what they would do with the savings if these inefficiencies were weeded out, hospital officials’ most common responses were:

Reinvest in patient care	89%
Purchase new equipment	84%
Make capital improvements	77%
Pass savings along to patients	54%
Apply to indigent patient accounts	50%
Expand workforce	39%

Source: Improving Quality/Reducing Cost of U.S. Healthcare by Improving Administrative Efficiencies, PNC Financial Services, March 2007

Processing: From Clean to Cash

Insurers say they are getting better—and quicker—at processing “clean” claims. A 2006 survey from the industry’s main trade group says 98 percent of claims are processed within 30 days of receipt.

Percent of claims processed in 14 days or less

2002	71%
2006	81%

Source: America’s Health Insurance Plans, May 2006