



Drive Denials Down to Drive ASC Revenue Up

Drive Denials Down to Drive ASC Revenue Up

Billing is one of the most critical (and often overlooked) processes in the success of every surgery center. Most people involved in directing and operating ASCs know that billing and coding require daily attention to detail, trained staff, and a solid understanding of ever-changing payer “rules.” Yet, somehow, the importance of “denial management” is still not understood very well, even though it is a trendy buzzword.

AT A GLANCE:

1. Denial prevention, not denial “management”
2. Understand current center performance
3. Apply the “80/20” rule
4. Develop action plans

In fact, denial management is treated in many different ways based on the construct of a center’s business functions. This article will describe one successful approach for managing and preventing denials.

Before we jump into suggestions, we’d like to make some observations. First, it appears that some centers view denial management as the “catch all” for un-resolved claims. This attitude creates a negative perception, and makes it uninverting for staff members to dig in and resolve open issues, which can lead to a larger pile of open issues.

Other centers appoint senior staff members to deal with denials and make sure they are resolved quickly. But many of these centers don’t have metrics in place for denial rates, or an understanding of what causes the denials. Appointing senior staff members to handle denials is the proper approach if the end goal is to improve denial processes, but it is not a good use of time if they are merely correcting a denial and re-submitting the claim for payment.

We prefer to take a comprehensive approach. From that perspective, “denial management” appears to be a misleading label that should be replaced by “denial prevention and management.” How did we come to this approach? Like everyone else, we started with a number of denials to resolve. Then, we realized that the denials could be viewed as “defects”, leading us to a holistic approach using basic quality improvement or TQM techniques.

The first step in this approach is to analyze the causes. In our case, we analyzed a sample of 30,000 claims and the resulting 1500 “first pass” denials and found that, like most analyses of this type, an “80/20” pattern emerged: the majority of the denials were caused by a small number of reasons. For example, “patient not insured” (a claim incurred before/after coverage) was at the top of the list. In most cases, this was caused by incorrect insurance information, such as transposed digits, old insurance card, etc.

From looking at the root causes, it became clear that many denials are preventable—but not by the billing department. Everyone knows that accurate billing starts the first time a patient interacts with the center. But showing hard data with a preventable denial rate (or error rate) of five to 10 percent or

Drive Denials Down to Drive ASC Revenue Up

more makes the costs of the errors and the benefit of denial prevention, much more tangible.

Now, let's consider the costs associated with resolving a denial caused by incorrect insurance information. First, the billing staff receives the denial and looks for the specific data elements required to resubmit the claim. When they realize the insurance information submitted matches the center's records, it's time to call the patient, assuming there is a reliable phone number, and wait for a call back. Or, the staff may call the referring physician's office for the accurate data. Once the correct information is obtained, the claim can be updated and resubmitted. Let's add up the costs: nearly an hour of billing staff time (\$20 with conservative loading); ten or fifteen minutes for the referring physician's staff (\$5); and three to six weeks delay in getting paid (\$30 for one month's delay on a \$3000 payment). The total: over \$50 per "simple" error. If the error rate is five percent—which is actually lower than many centers—for a center that does 300 cases per month, the center is incurring an annual cost penalty of \$9,000. Plus, don't forget the referring physician's costs, the impact on patient satisfaction from the follow-up calls, delayed cashflow, and an increase in days in A/R.

Considering the costs and the nature of these potentially preventable denials, it becomes obvious that improving the quality of information at the front-end will result in significant benefits on the back-end. With that said, here are some of the practical steps that we have found successful:

AWARENESS AND TRAINING

This obviously includes the front-end staff—especially schedulers and intake personnel. But, it must also include referring physicians' office staff. In addition, educating the physicians themselves can be very helpful. It's important to remember that mistakes happen at the "seams"—the handoffs between individuals and organizations. Educating each person about how the information they "produce" is used by others can be very effective.

SOLID PROCEDURES AND JOB AIDS

As an example, schedulers should know that obtaining or confirming insurance information is a key job responsibility for every call. They should have a checklist or form (on paper or a computer) that highlights each piece of information required. For instance, simply getting the primary insurance number is often insufficient—leading to a denial. This happens when the patient has secondary insurance, or when it is a motor vehicle or workers' compensation case. When the patient presents, the intake person should confirm each piece of information, including a comparison with the patient's insurance card. They should then ask, "Is this insurance still in effect?" and "Are you still employed by the same employer?" It's not uncommon in today's economy to have someone covered at the time the surgery is scheduled, but not when the date of surgery arrives.

An even better procedure is to verify the patient's eligibility when they are scheduled or when they present, or both. This procedure also allows the center to know the exact amount for which the patient is responsible, and collect some (or all) of it prior to surgery (a recommended best practice). We have seen great examples where the referring physician provides the patient with all of the necessary forms to be sent to the center at time of scheduling; that way if the information is incomplete, a call is made

Drive Denials Down to Drive ASC Revenue Up

PHYSICIAN DOCUMENTATION

Many denials for medical necessity result from incomplete documentation that eventually gets updated and may result in payment, but only after an amended claim is filed (e.g.: an ACL repair that is denied for medical necessity because the tear and previous steps at mitigation are not initially documented). However, the costs of the error are much higher than the \$50 for an error in insurance coverage since they involve both staff time and physician time.

There are also some instances where the details of the procedure are not clear, requiring the coder to code to the lowest common denominator or request additional documentation. To combat this, try periodic education and/or reminders for physicians. These can be done in conjunction with board meetings. And some centers have been very successful with an occasional “open house” for referring physicians and their staff. Usually in the evening with food, these informal settings can not only promote the ASC, but also show attendees how they benefit from following the recommended processes, using the proper forms, etc. If one or more referring offices perform better than the others, have them explain their success and follow up with a one page summary that others can carry away. It is important for each stakeholder, and particularly the physicians, to understand that a very successful clinical outcome might result in a poor business outcome if all parties involved do not perform with precision and accuracy.

As these examples illustrate, there are a number of practical steps that can reduce denials substantially. Think about denials in two categories. Those deemed as “first pass” denials are caused by a process error that shouldn’t have happened. In other words, these are preventable denials.

On the other hand, “second pass” denials are those which may truly result in no payment; or which require substantial additional effort to collect. Fortunately, this category is much smaller than the first. Second pass denials include those where medical necessity is questioned by the payer. In some cases, this can be a result of incomplete documentation by the surgeon (another preventable error), but there are cases where the payer prevails. Another second pass cause can be timely filing, assuming it isn’t caused by documentation or other preventable delays. Finally, there can be a legitimate “patient is not covered” denial, which is the reason for the intake questions suggested earlier about whether insurance is current.

Each center should establish targets for first pass and second pass denial rates. We’ve been asked about industry benchmarks for these targets. However, our experience shows that denial rates vary significantly depending on payer mix (workers’ compensation and motor vehicle cases generally drive the rate up), locale, and in-network/out-of-network mix. A center that is primarily in-network with otherwise favorable factors should probably target second pass rates in the one to two percent range. A center with a less favorable mix may target a rate closer to five percent.

First pass denial rates have similar variability. Here, the exact benchmark is less important than understanding the current performance of the center. This analysis is the critical first step in “denial prevention and management.” After all, nearly everyone has heard the famous Peter Drucker quote, “You can only manage what you can measure.” Start by looking at denials over the past three to twelve months, using transaction codes or similar mechanisms available to generate the data. Look at the

Drive Denials Down to Drive ASC Revenue Up

trends by type, by payer, by surgeon, and by location if you have more than one. You might also look at patterns by day of week and by surgery type.

This analysis will provide your “80/20” insight. The next step is to take the twenty percent of issues that cause eighty percent of the denials and identify the ones to be addressed with staff education, procedures and job aids, the ones that require surgeon involvement, and ones that can be dealt with directly by the billing staff. As with the implementation of any complex process, start to eliminate one root cause at a time. This will enable staff members to gain insight to the process, recognize some substantial wins, and see the fruits of their labor.

As you implement these action steps, be sure to track and analyze the denials, at least monthly. You will most likely see a substantial reduction, followed by continuous, incremental reductions. And you should see a cost reduction from the combination of less billing staff time and lower error rates throughout both front-end and back-end processes. In our billing operation, we've had success tying monthly and quarterly employee bonus payments to a combination of productivity and quality, where quality is measured by error rate. We don't recommend this as a first step, but it is an example of integrating improved quality into the fabric of an operation.

As your process matures, pay particular attention to payer patterns. In today's fluid environment, you may experience jumps in denials from payers that had low rates just a few months ago. We should also point out that the same analysis should be applied to claims not paid in full--those should be thought of as partial denials. Payer patterns and trends are particularly useful for these cases since they equip the center for a discussion with the payer about payments versus contracted rates.

We hope you find these suggestions useful and that you can apply at least one or two to your center's operations. Let us know what works, and what doesn't work—we are always looking for ways to drive denials down and revenue up!