Study on Claims Denials

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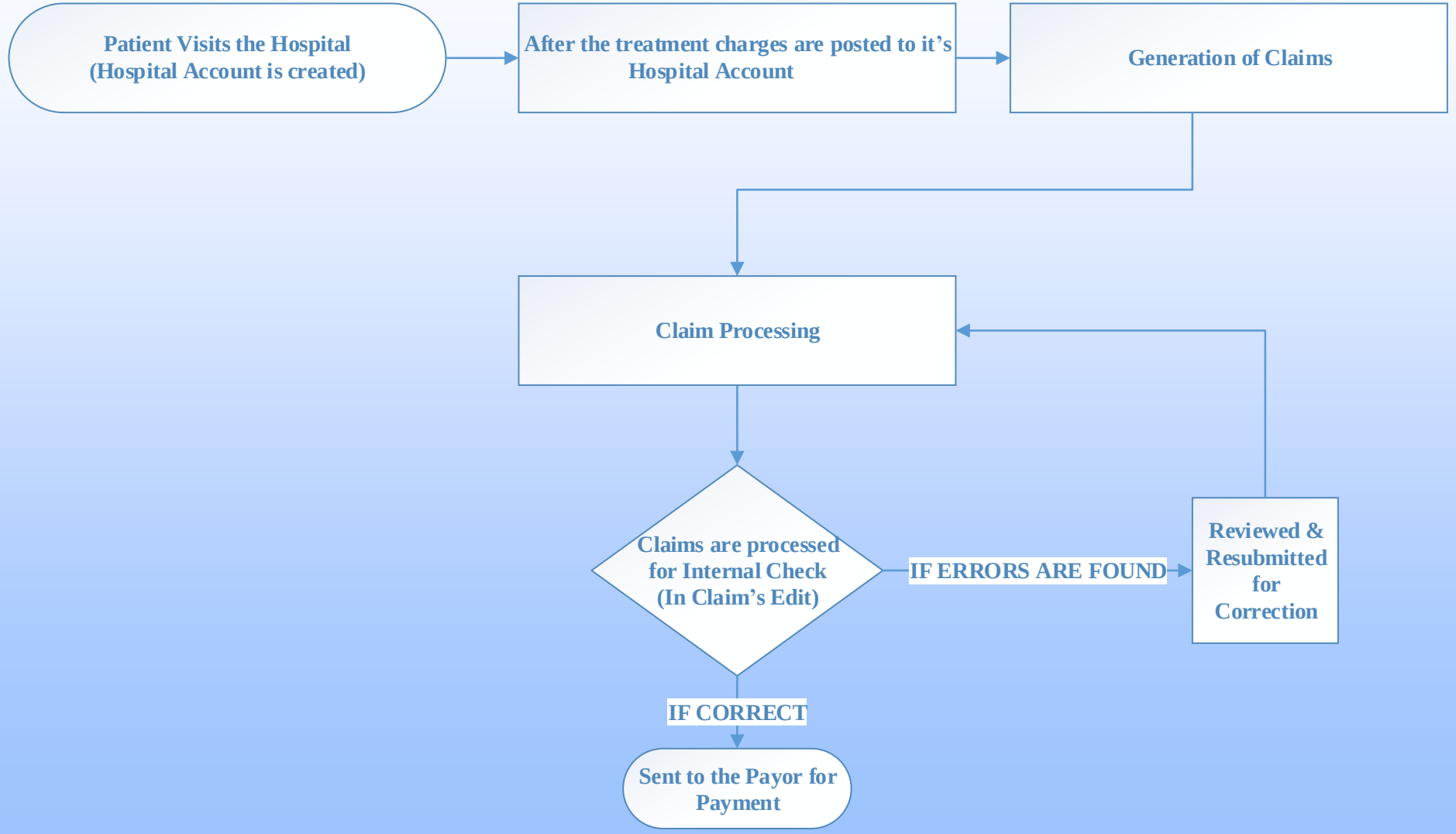
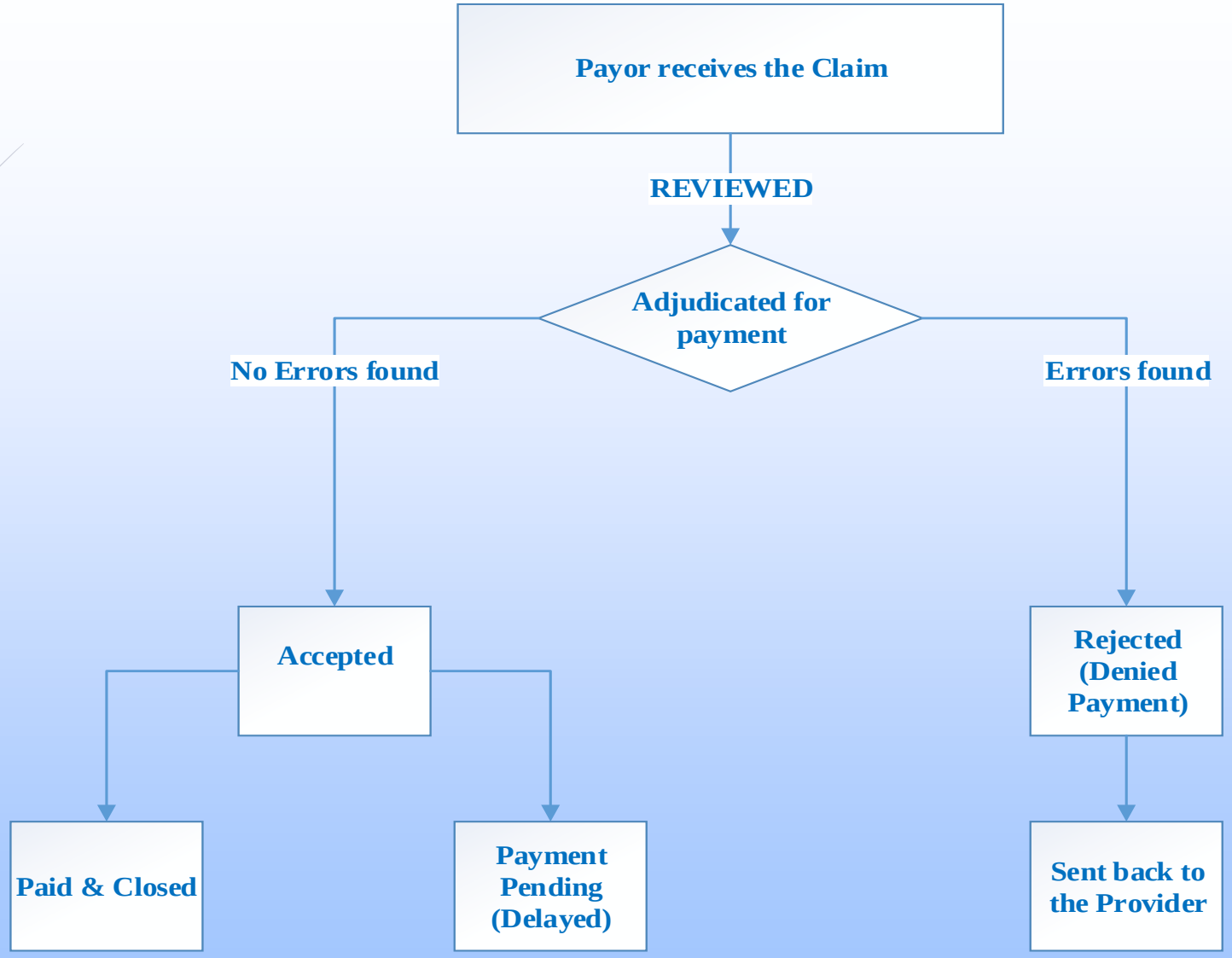
Introduction

- A clean claim has many definitions, but for our purposes it is a claim that was accurately processed and reimbursed the first time it was submitted to the payor. Submitting more clean claims and reducing denial rates can be challenging due to complex and changing payor reimbursement policies and procedures.
- The average U.S. hospital has a clean claims rate ranging from about 75-85%.
- Every medical practice experiences claim denials. Better performing practices have denial rates below 5%; other practices are seeing claims being denied 10%, 20% or in the extreme 30% of the time.
- Working denials is like pumping water from your basement when a pipe bursts. Denial management is about fixing the pipe so you no longer need to pump water from the basement

Process Flow




Payor receives the Claim
REVIEWED
Adjudicated for payment
No Errors found
Errors found
Accepted
Rejected (Denied Payment)
Paid & Closed
Payment Pending (Delayed)
Sent back to the Provider

Problem statement

Health care organizations face heavy losses every year as a result of claim rejections and denials, and this in the long run affects the productivity and sustainability of the medical practice to a bad extent.

Rationale of the study

Claim denials can be a major source of frustration for physicians and their practice managers, and can have a real impact on cash flow and the financial performance of a practice. Sometimes, the denial stems simply from the fact that the claim had some kind of error. In 2012, the American Medical Association reported that an average of 9.5% of health claims processed by private health insurers contained errors. Knowing the major areas of these errors can help reduce the number of claim denials, thereby lowering the turnaround time of the claim payments.

Research questions

- What is the turnaround time of claims payment?
- How much does claim denials account as a percentage of claim delay?
- What are the areas and reasons for claim denials?
- How can the denials affect the revenue cycle management of the provider?

Objectives

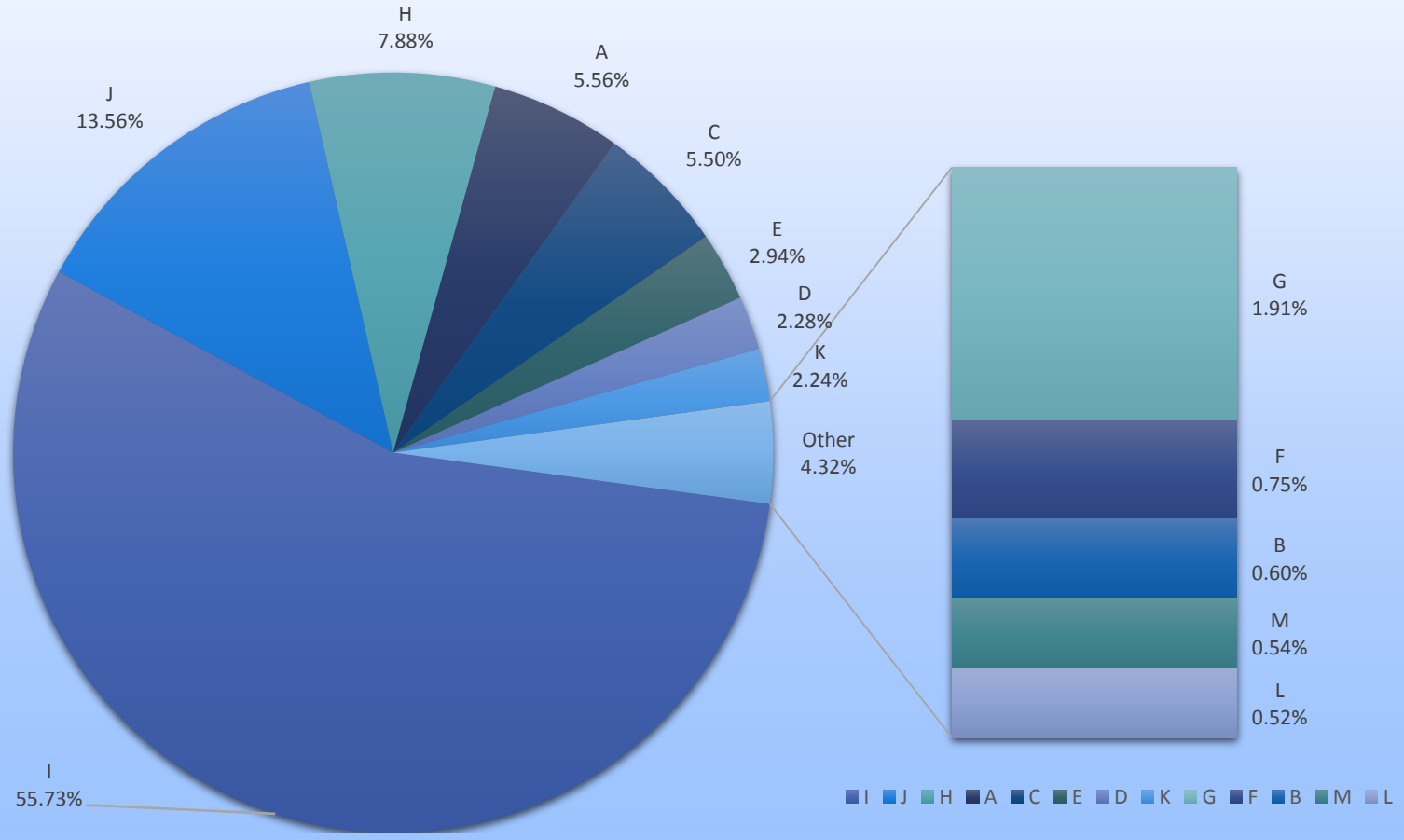
1. To determine the turnaround time of claims payment
2. To find the percentage of claims denied by the Payor
3. To find the reasons of claim denials
4. To determine the impact of denials on revenue cycle of the facility.

Methodology

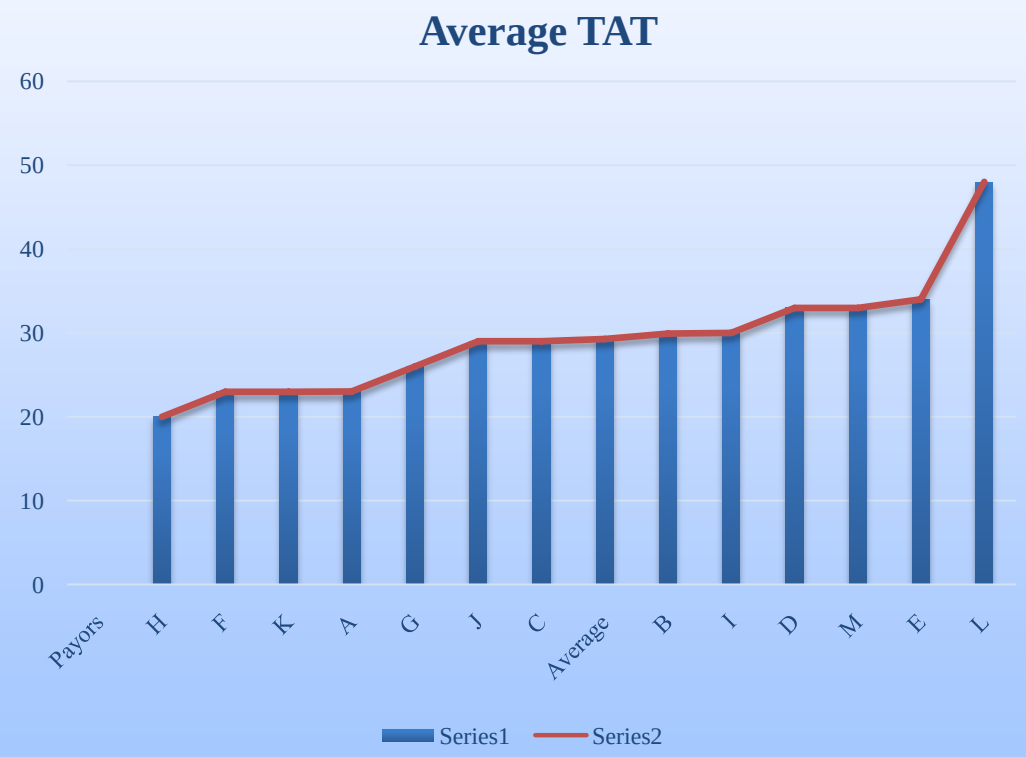
- Study design: This is a Cross sectional Analytical study on Quantitative data pertaining to claims of the patients generated in a US based hospital.
- Study time line: The study was conducted over a duration of 2 months.
- Study population: Data on claims generated in a particular US based Healthcare Facility over a period of one month.
- Sampling: Sampling procedure used was Accidental non probability sampling with a sample size of 171 denied claims from 13 payors.
- Data collection:
  - Technique: Data is collected through desk research.
  - Data type: Secondary Data

Analysis

Proportion of claims of each insurance company

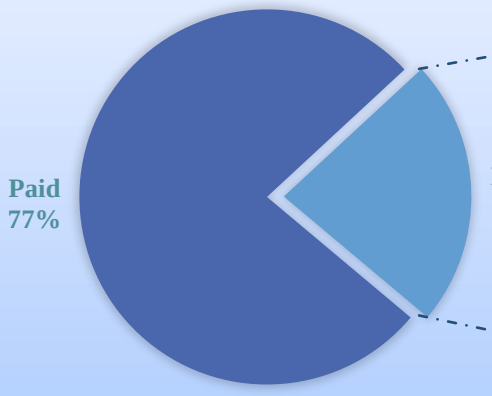


Turn-around time

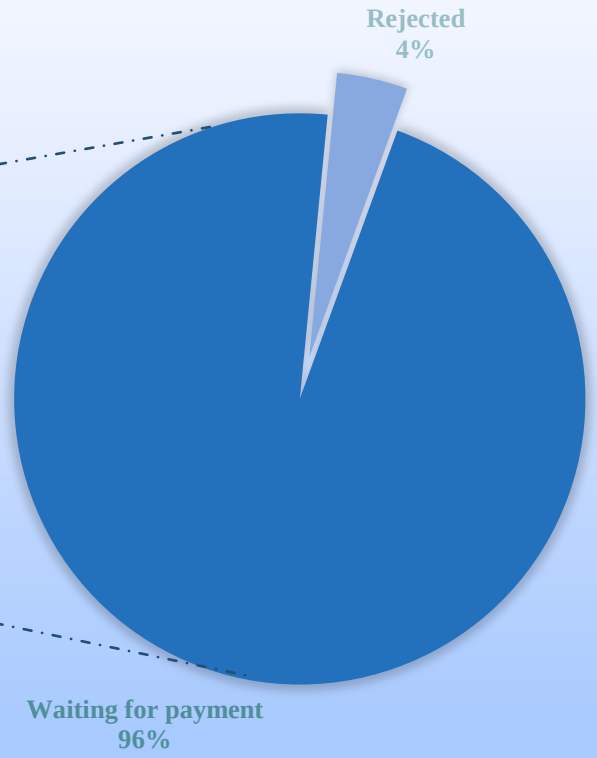


Payors	TAT(days)
H	20
F	23
K	23
A	23.03
G	26
J	29
C	29.03
Average	29.3
B	29.94
I	30
D	33
M	33
E	34
L	48

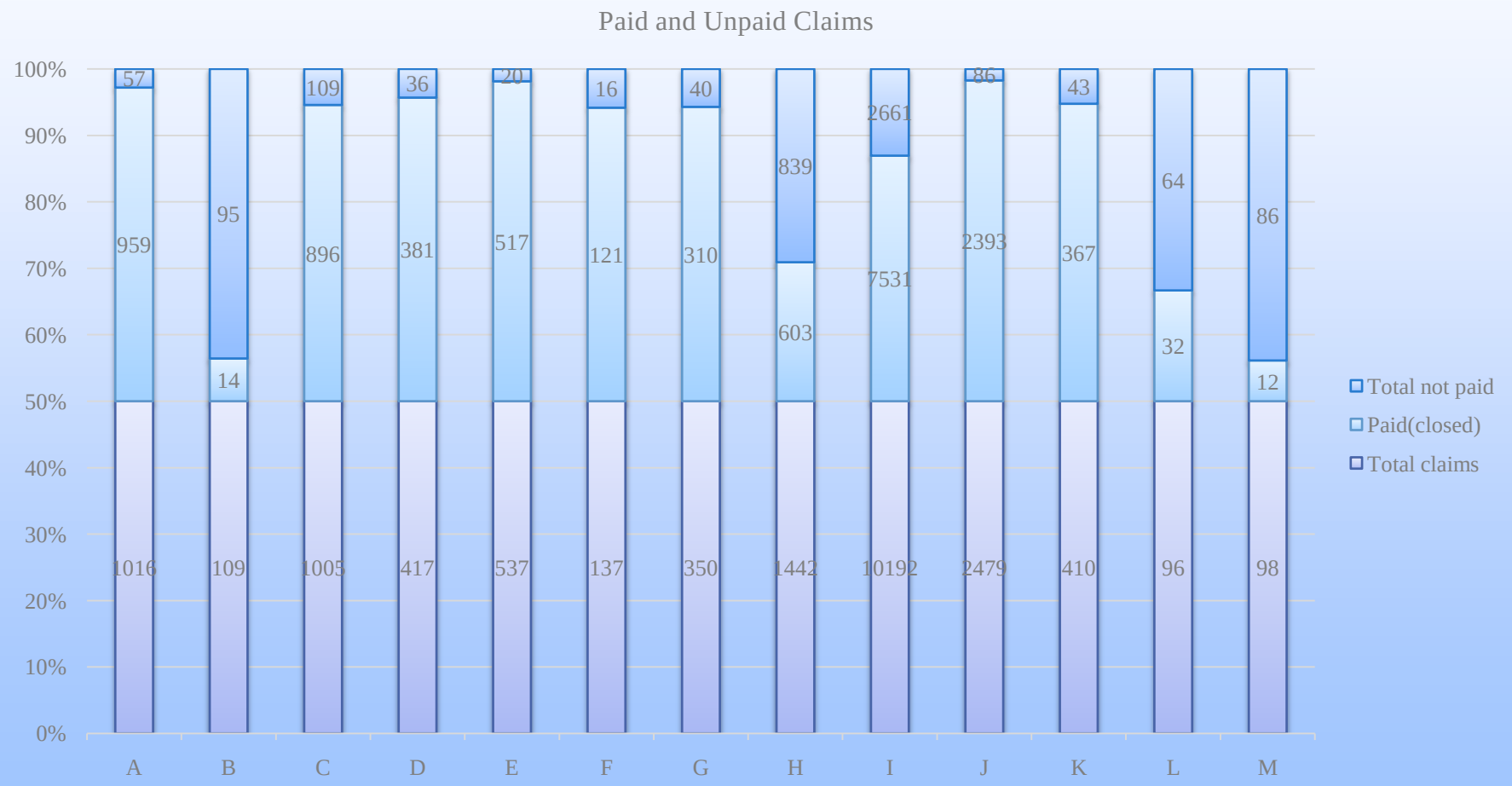
Proportion of claims paid and not paid



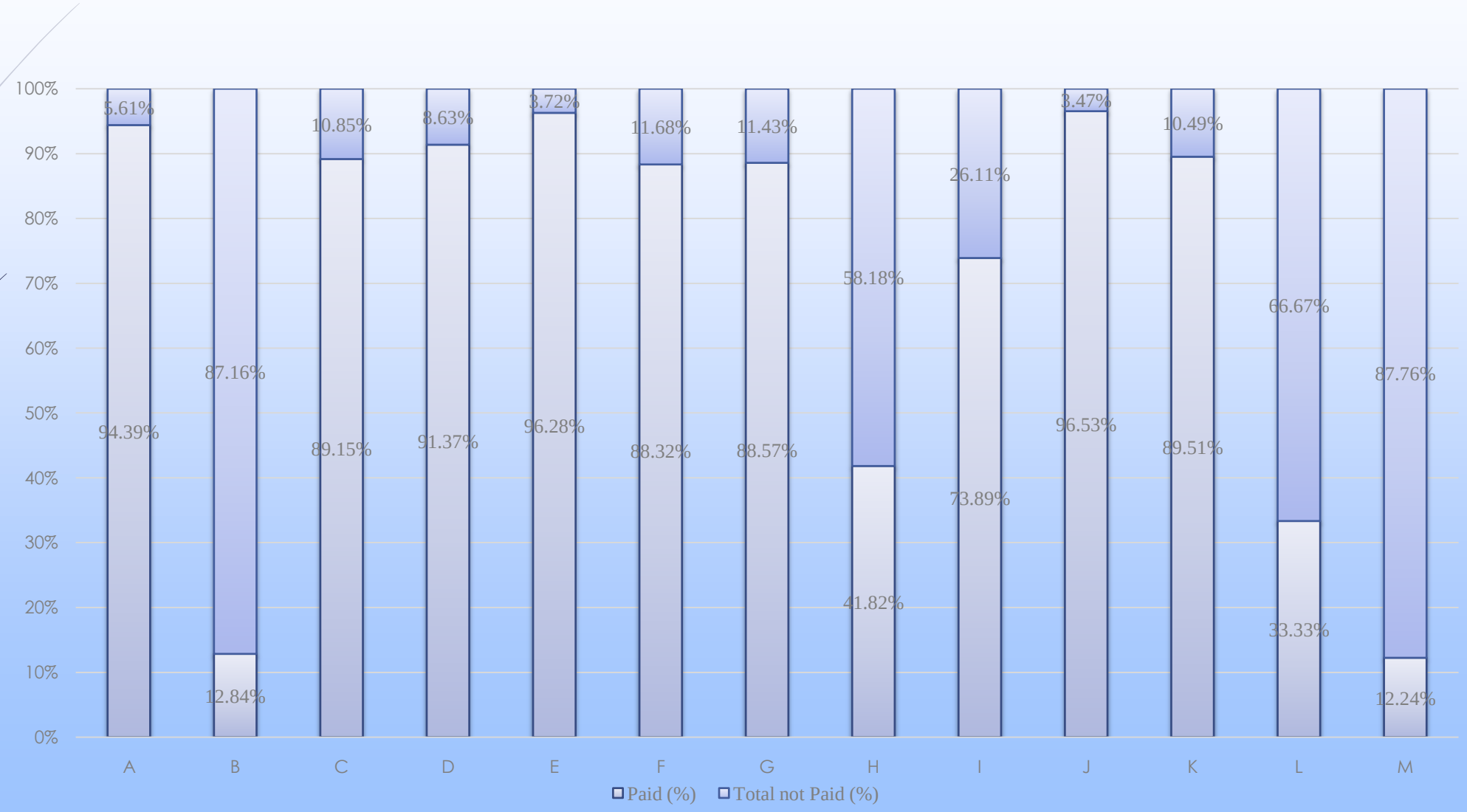
Proportion of claims accepted and rejected



Proportion of Claims paid and not paid for each Payor

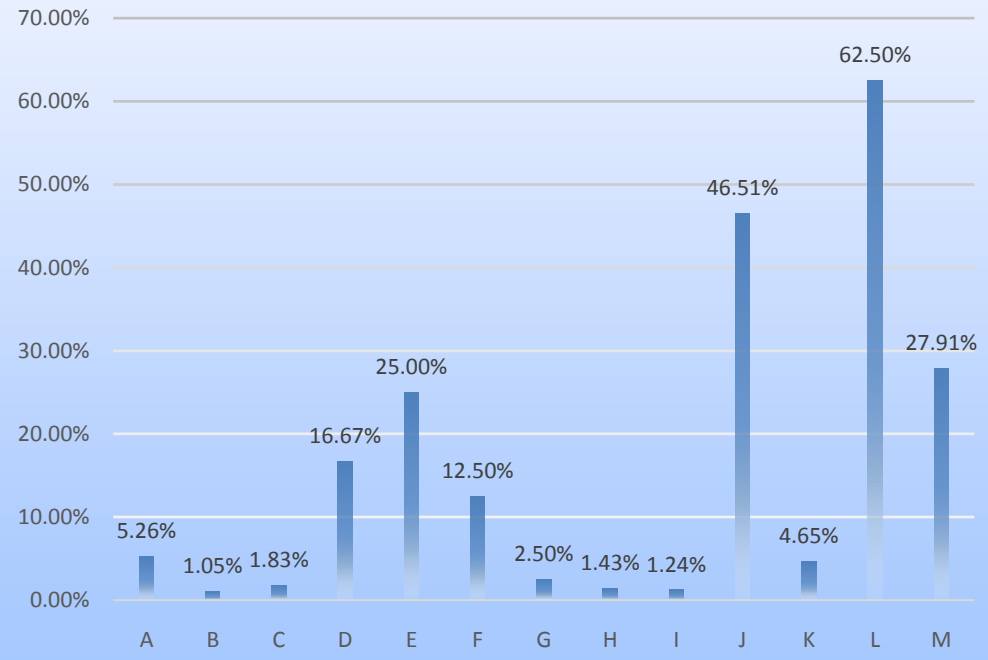


Proportion of Claims paid and not paid for each Payor in percentage

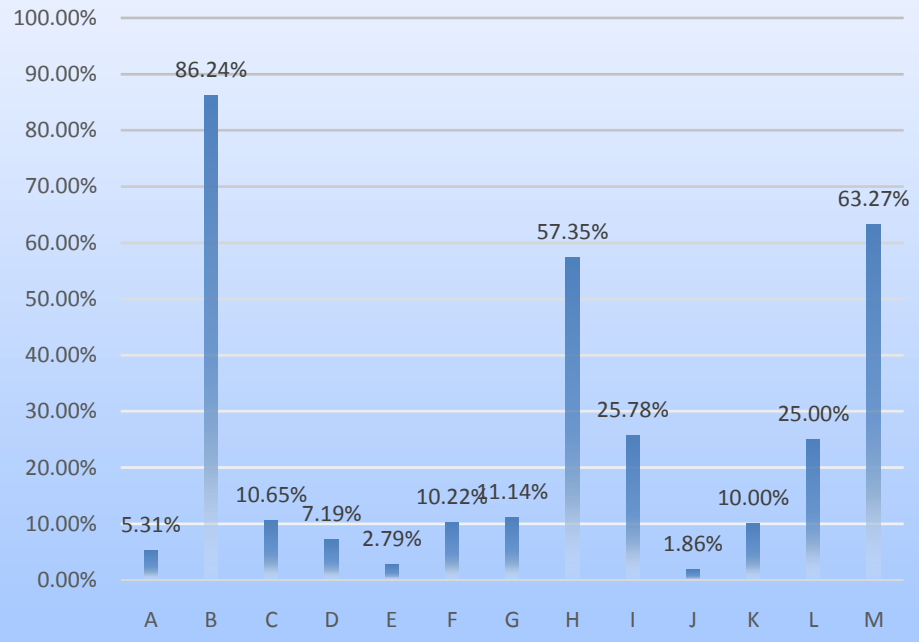


Denial and Delay rate for each payor

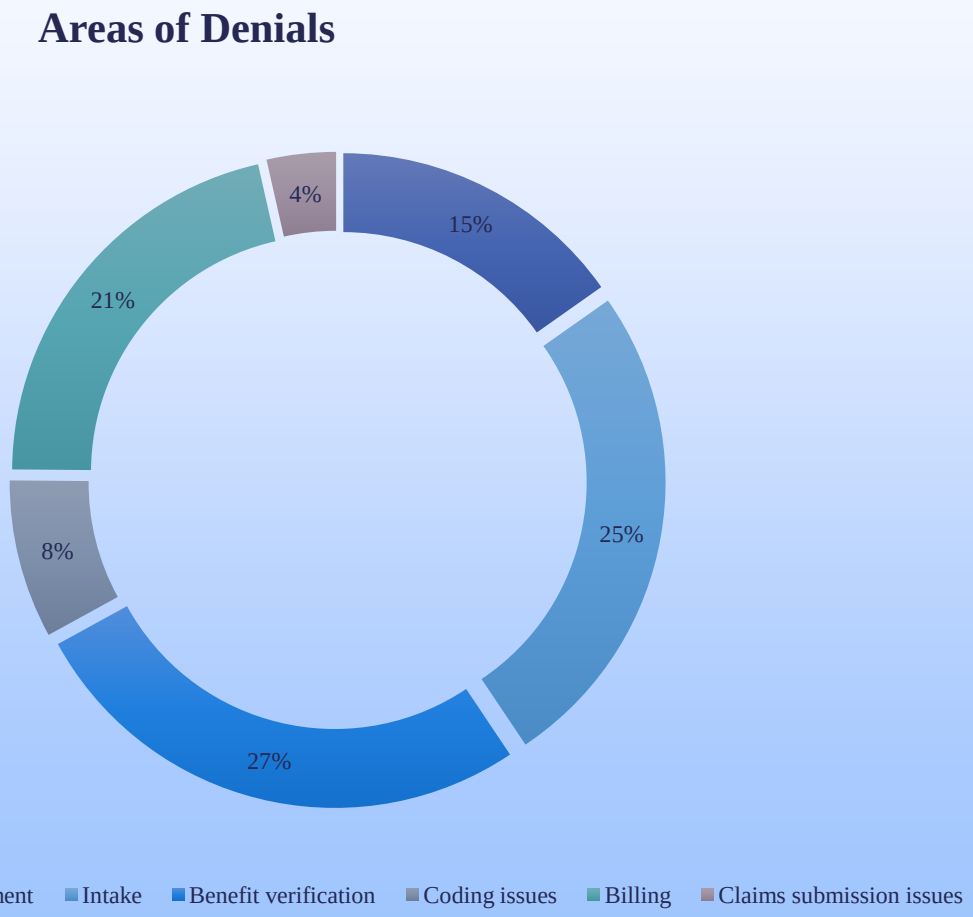
Denied claims



Delayed claims



Result



Benefit verification(27%)
Member not eligible
Other insurance
Non-covered charges
Authorization/referral needed
Out of network provider
Patient not identifiable
Coverage terminated
Benefit maximum met
Capped services

Intake (25%)
Additional info needed
Not medically necessary
Not eligible to provide service
Incorrectly prescribed
Liability/work related claim
Incorrect/incomplete Rx
Not prescribed by Physician
Service not provided is documented

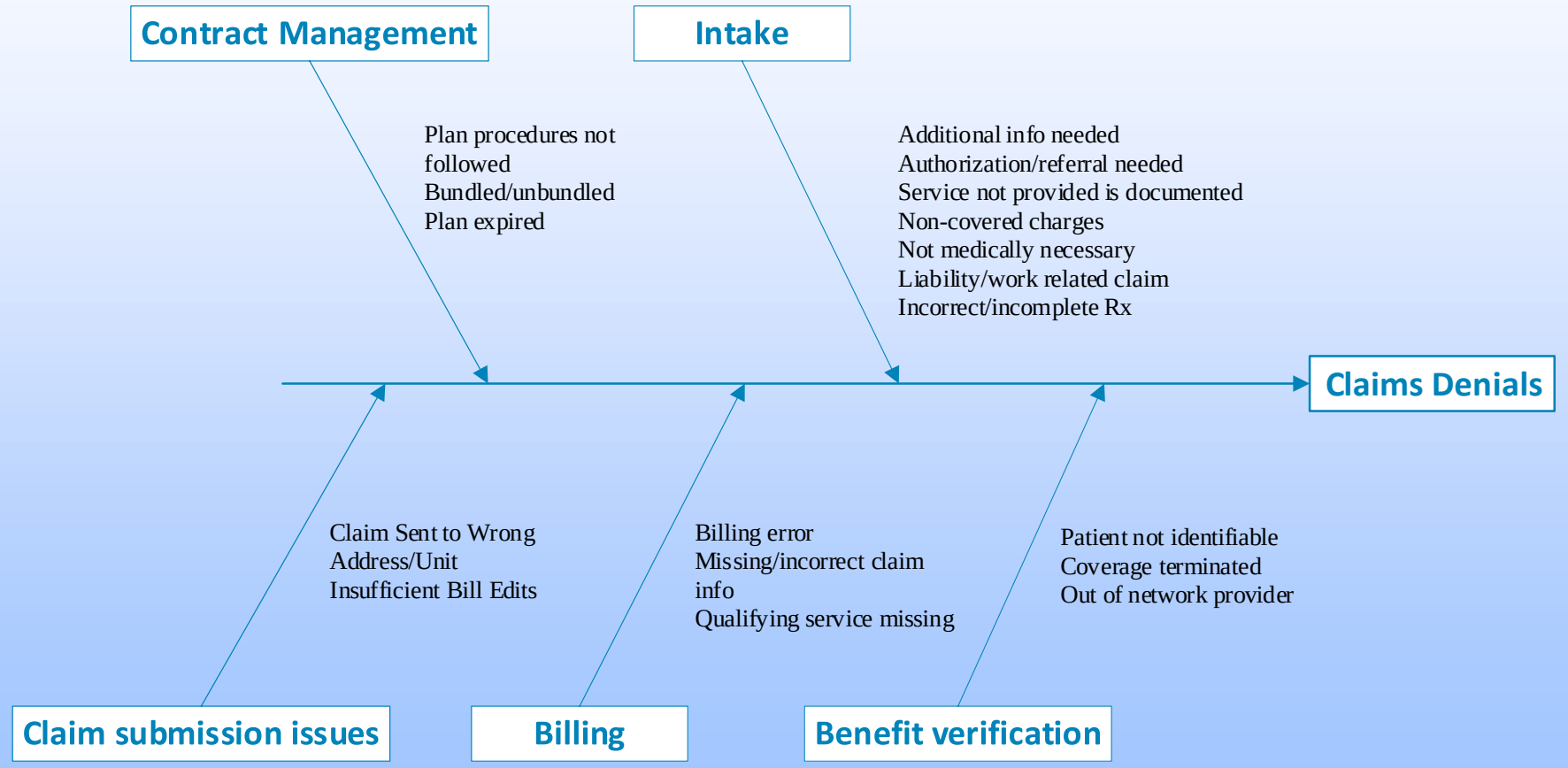
Billing (21%)
Past timely filing
Billing error
Previously paid
Qualifying service missing
Missing/incorrect claim info

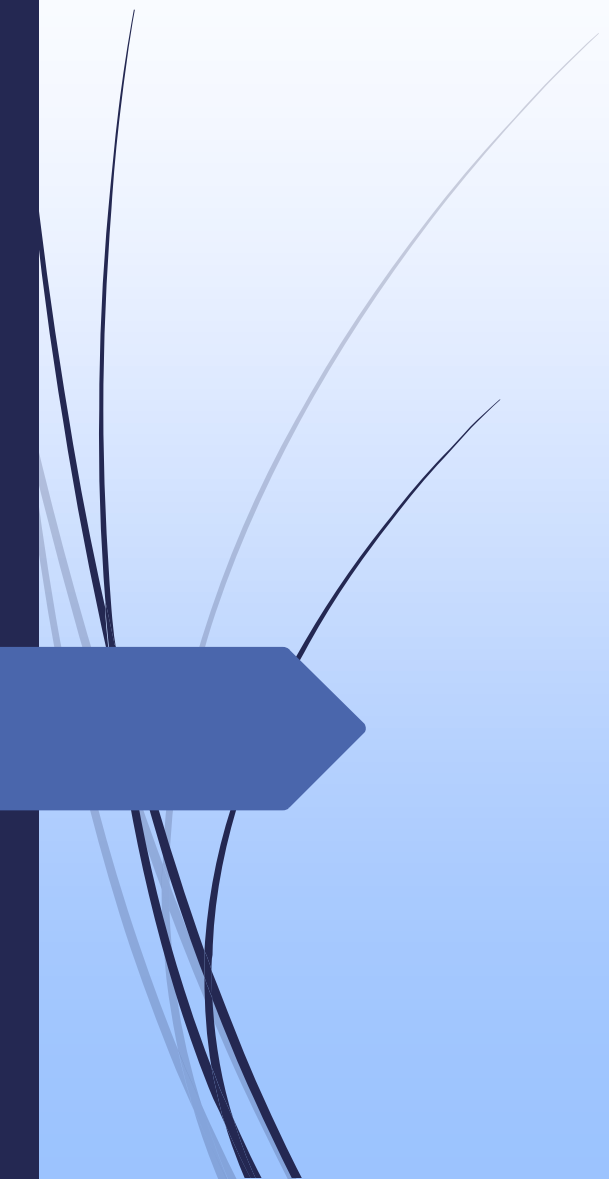
Contract Management(15%)
Plan procedures not followed
Bundled/unbundled
Plan expired

Coding Issues (8%)
Incorrect coding

Claim Submission Issues(4%)
Insufficient Bill Edits
Claim Sent to Wrong Address/ Unit

Cause and effect diagram for claims denial





Discussion and Recommendation

The current trend of the claim denials shows that the denials can be categorized as :

- Hard Denials: Those denials which requires appeal for their corrections. These include

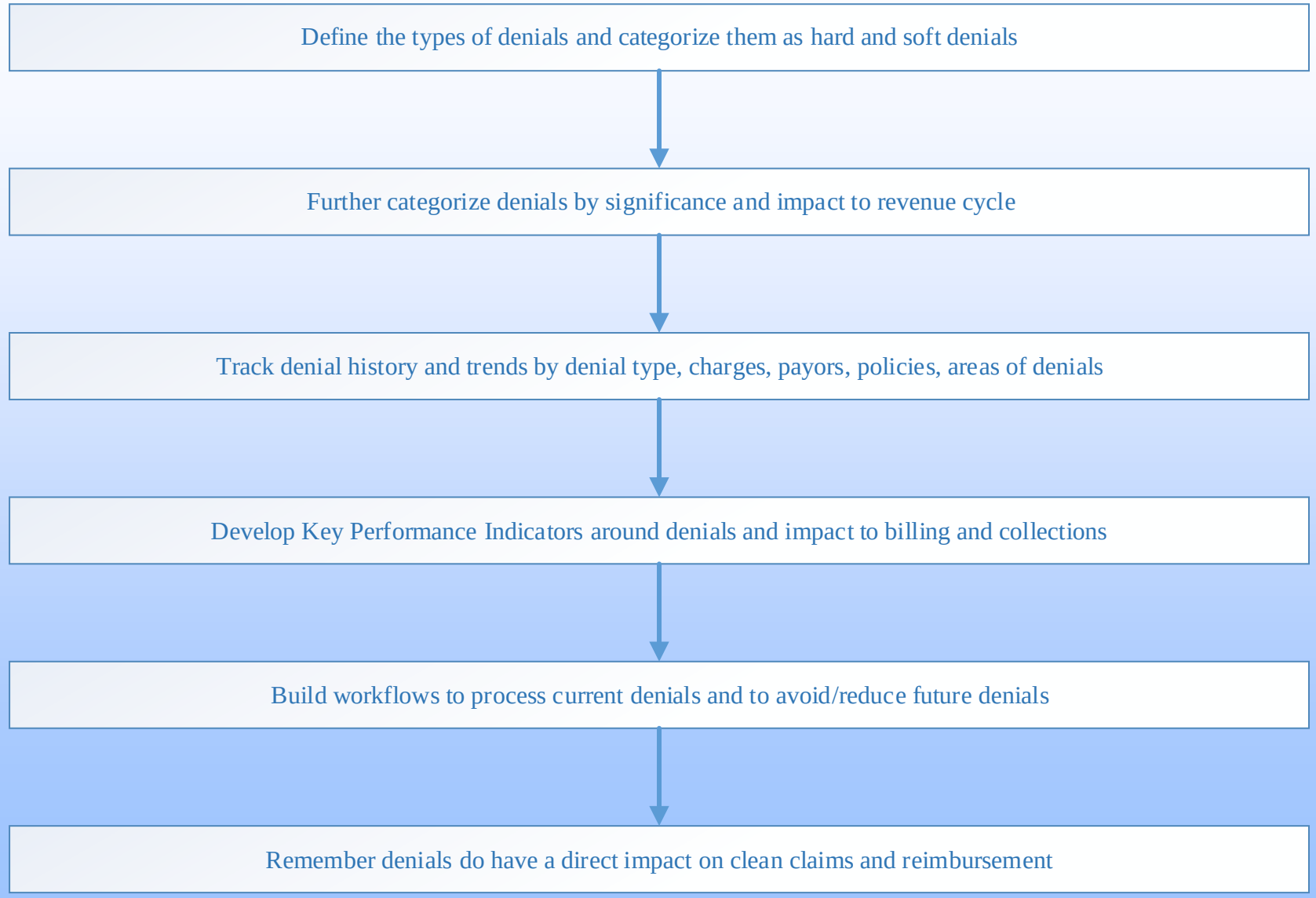
1. Denied claim for elective service without pre-authorization
2. Denied days, service, or level of care for no concurrent authorization or lack of medical necessity
3. Denied due to charge/coding issues

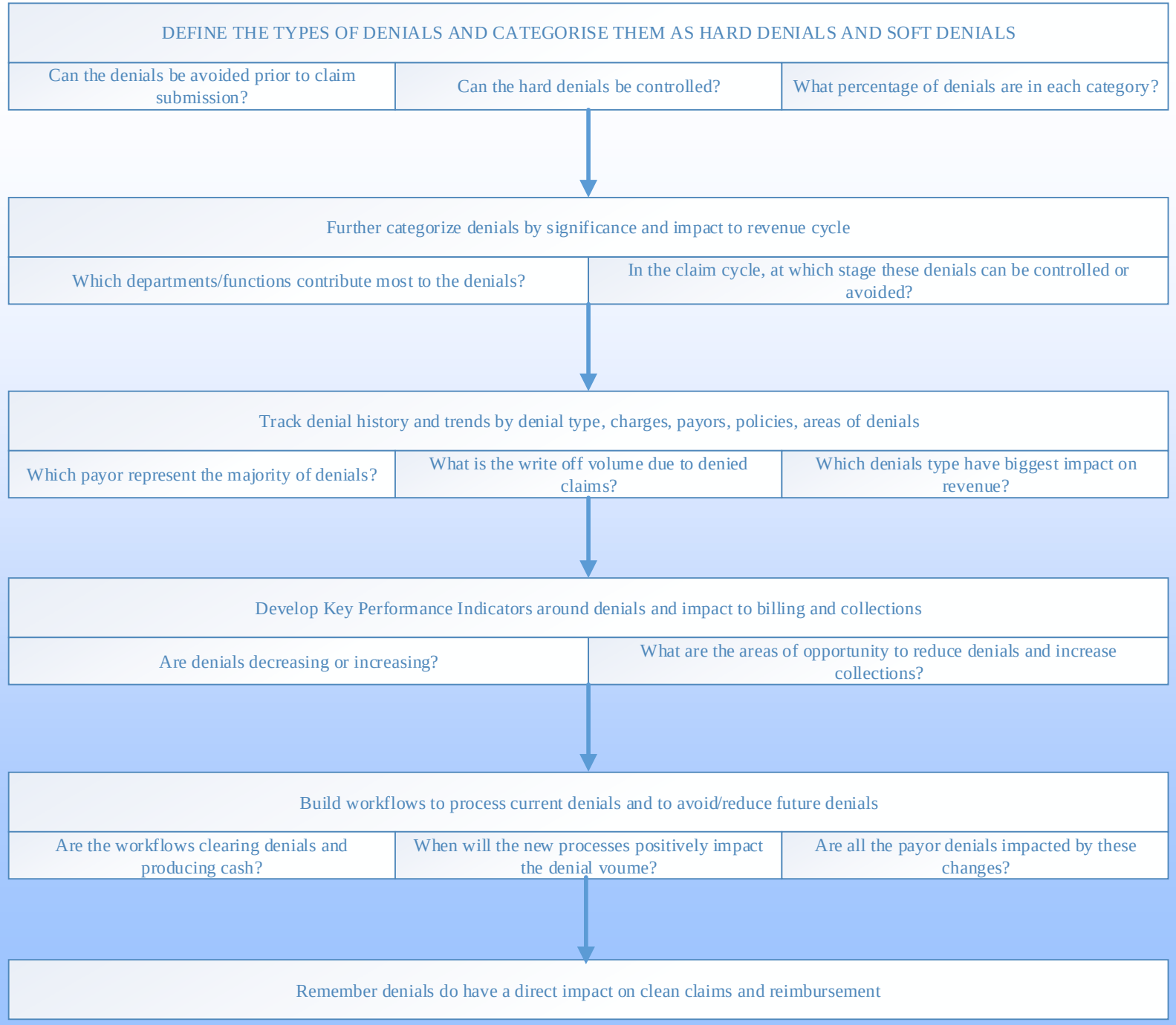
- Soft Denials: Those denials which only requires additional information for correction.

1. Denied claim due to missing/inaccurate information
2. Denied charges pending receipt of itemized bill

Denial management system must be established and implemented in order to avoid these denials in future.

Denial management




DEFINE THE TYPES OF DENIALS AND CATEGORISE THEM AS HARD DENIALS AND SOFT DENIALS
Can the denials be avoided prior to claim submission?
Can the hard denials be controlled?
What percentage of denials are in each category?
Further categorize denials by significance and impact to revenue cycle
Which departments/functions contribute most to the denials?
In the claim cycle, at which stage these denials can be controlled or avoided?
Track denial history and trends by denial type, charges, payors, policies, areas of denials
Which payor represent the majority of denials?
What is the write off volume due to denied claims?
Which denials type have biggest impact on revenue?
Develop Key Performance Indicators around denials and impact to billing and collections
Are denials decreasing or increasing?
What are the areas of opportunity to reduce denials and increase collections?
Build workflows to process current denials and to avoid/reduce future denials
Are the workflows clearing denials and producing cash?
When will the new processes positively impact the denial voume?
Are all the payor denials impacted by these changes?
Remember denials do have a direct impact on clean claims and reimbursement

Key Functions of Denial Management:

- Maximize cash flow - Reporting identified denial causes having the greatest financial impact, thereby accelerating cash flow.
- Identify the root cause of denials - Collecting and interpreting denial patterns to quantify denial causes and their financial impact.
- Support accurate workflow priorities and scheduling for follow up - Collecting information on denial appeals, including status, escalation, correspondence with payors, and the disposition of denial appeals to increase recovery amounts.
- Provide accurate and timely statistics for Management / Clients - Providing management analysis reports and other information to prevent future denials.
- Track, Prioritize & Appeal denials - Generating appeal letters based on federal and state statutes and case citations favoring the medical provider's appeal.
- Avoid out-of-timely filing.
- Analyze the effectiveness of denial resolutions.
- Identify business process improvements to avoid future denials

Conclusion

- Best practice is to trend and track the denials at the time of posting the payments
- Denials should be tracked by payor, type of denial, and provider. Staff members must be assigned to work denials on a regular basis, daily for a large medical practice

Keys for prevention:

- Understanding the root cause
- If it is internal, communicating and collaborating internally to update processes that will mitigate denials in the future
- If it is external, communicating and collaborating with the payors to update processes

Limitations

- Data pertaining to reasons for delays cannot be obtained because it is at payor’s end the study is being conducted at the provider’s end.
- Impact of denials on revenue cycle management of the provider, in terms of the time of employee spent on the correction of denied claims, cannot be calculated.
- Name of the insurance companies (Payors) included in the study are de-identified because of PII and PHI regulations.
- This study is done only for one hospital and data collected was of only one year, and hence cannot be generalized for the complete US Healthcare Market.


Thankyou