Availity®

Why manage what you can prevent?

4 Steps to stop recurring denials

Sometimes it feels faster to work around a recurring challenge than to get to the root of the problem.
But if that problem is claim denials, ***you're leaving money on the table***.
Find out how simple it can be to identify and stop denials ***before*** they happen.

Connecting the Network of Healthcare

Introduction

At the time of this publication, many hospitals and health systems have just barely recovered from more than a year of negative operating margins. While patient revenue has largely stabilized, inflation and exploding labor costs could make this recovery precarious at best. Additionally, many providers report increasing denial rates, creating a perfect storm of too many denials to manage and not enough staff to manage them.

An estimated 80–90% of denials are avoidable with the right processes and tools.

In this eBook we share examples of our tried-and-true Countdown Method to preventing denials. This focused, proactive, and repeatable approach empowers the revenue cycle staff you already have to improve processes and respond to changes in reimbursement.

Denials are costly

$25 and up to **71 MINUTES** to work a denial[1]

$286 BILLION in annual waste from administrative complexity[3]

50–65% of denied claims are never resubmitted[1]

$118 per denied claim to appeal[2]

REDUCED patient and staff satisfaction and trust

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The countdown method for denial prevention

Creating a repeatable denial prevention strategy is as easy as **4, 3, 2, 1.**

Identify your organization's top **4** denial categories.

Focus on **3** root causes of those denials.

Implement 2 options to address those causes.

Apply 1 measure of success and celebrate!

Let's get started.

Just a few common, preventable denial categories include:

- Duplicate claims
- Coordination of benefits (COB)
- Medical documentation
- Timely filing
- Authorizations and referrals

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Identify top 4 denials

The first step in our process is to identify the top four broad categories of preventable denials most affecting your business. Take advantage of the analytics tools in your clearinghouse, PMS, or HIS to discover those categories from the past 60–90 days. Payer rules and systems change, so it's important that your snapshot is recent. By limiting your date range, you eliminate denial issues that are already resolved or may be less pressing for your organization right now.

Isolate each denial category into one of four buckets, because you're going to tackle one bucket per quarter. Start with the easiest bucket to resolve first — this will help with change management on your team and provide results right away.

Start with an easy win to keep your team motivated to make changes.

What *not* to tackle

These denial categories are either not preventable or fall squarely outside the "easy win" category.

- **Patient coverage**
- **Patient responsibility**
- **Recovery Audit Contractor (RAC) recoupment**
- **Contractual obligations**

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Example

Availity worked with an academic medical center to identify their top denials. Based on the analysis, we selected Timely Filing as the area to focus on first. To isolate Timely Filings, we ran a report on their Claim Adjustment Reason Codes (CARCs) and included "29" (timely filing), which listed all service lines with that reason code over the last 90 days.

Top 4 denials: Duplicate claims, Coordination of Benefits, Timely Filing, and Medical Necessity

Adjustment Group With Reason	Adjustment Reason	Service Line Adjustment Count	Service Line Adjustment Amount
CO29	The time limit for filing has expired.	14,408	$16,951,629
OA29	The time limit for filing has expired.	624	$402,364
PI29	The time limit for filing has expired.	319	$152,486
PR29	The time limit for filing has expired.	842	$695,563
GRAND TOTAL		16,193	$18,202,042

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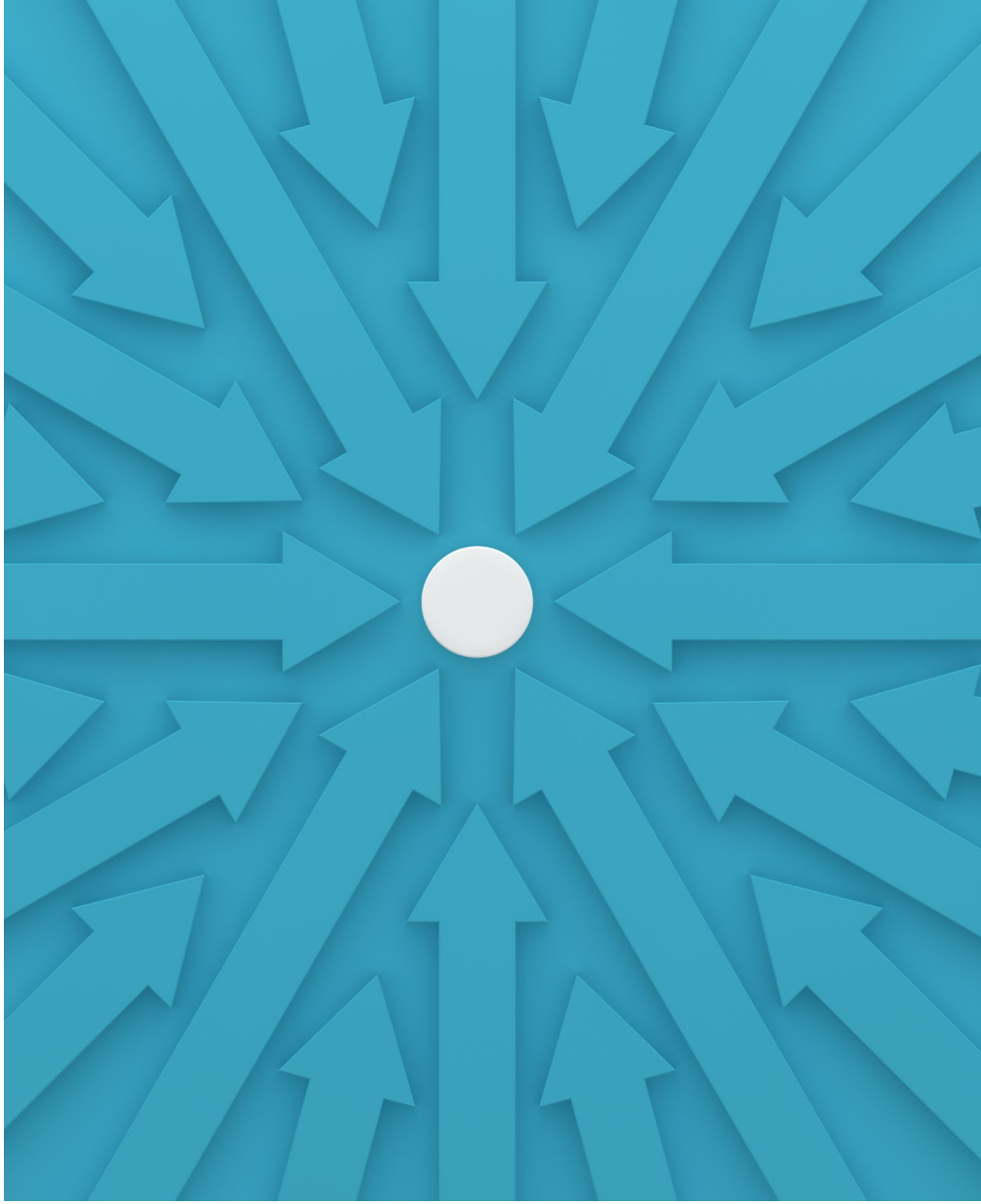
Focus 3 on root causes

Once you've identified a denial category you want to drill down on, it's time to look for root causes. Start by running a report each quarter on the last 60–90 days, and use Remittance Advice Remark Codes (RARCs) to categorize denials by cause.

Once you have your list of causes, we recommend assembling a multi-disciplinary team to help develop solutions for solving them. Bring in staff from registration, coding, payment posting, and clinical to brainstorm workflow improvements throughout the revenue cycle. Evaluate whether you can change or automate processes earlier in the revenue cycle to avoid these denials altogether. Don't get caught up in solving complex, one-off issues, and instead target those with the broadest impact.



The RARC lookup tool at x12.org is a great resource for translating codes.

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Example

Having identified Timely Filing as their first area of focus, our academic medical center client drilled down to the top three Remark Codes that were both preventable and could create measurable improvements when fixed. Those codes were:

1. Date of Service to submission is past contracted timeline (remark code may be blank)
2. No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated (N111)
3. Service not payable with other service rendered on the same date (N20)

See the full table of remark codes on the following page.

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Adjustment Group With Reason	Adjustment Reason	Remark Code Grouping	Service Line Adjustment Count	Service Line Adjustment Amount
CO29	The time limit for filing has expired.	Blank	13,917	$16,437,338
		MA44	275	$286,387
		N30	54	$86,517
		N111	83	$51,619
		MA44/N782	9	$44,554
		MA46	9	$18,010
		N45	23	$13,928
		MA44/N781/N782	1	$8,357
		N20	12	$4,994
		N123	10	$1,118
		MA67/N20	1	$390
		N377	1	$229
		N19	1	$95
		N694	1	-$229
		MA67	11	-$1,677
OA29	The time limit for filing has expired.		624	$402,364
PI29	The time limit for filing has expired.		319	$152,486
PR29	The time limit for filing has expired.		842	$695,563
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Implement 2 options

Having isolated a denial problem and its root causes in the first two steps, it's time to focus on fixing the problem upstream. We recommend choosing one option each for **process improvements** and **new tools**. To identify **process improvement** opportunities, thoroughly go through your:

- **Payer relationships and contacts to review rules and to problem solve.**
- **Payer contracts to ensure you're working from the most current copy and fee schedule.**
- **Registration process to establish whether you could do or collect something to prevent denials downstream.**
- **Charge entry and claim filing processes to ensure you're accounting for all claims.**

Be sure to contact your vendors to find out if they've introduced new features or services you can leverage. Consider implementing **tools** for:

- **Contract management to help you manage fee schedules.**
- **Claim editing (scrubbing) and applying standard and custom edits.**
- **Eligibility automation and posting back to your host system.**
- **Business intelligence (BI) to supplement your reporting.**

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Example

We recommended the following best practices to our academic medical center client to resolve their Timely Filing denials before they happened.

Improve their processes by:

- Monitoring average date of service to date of submission (DOS) for lag.
- Identify and isolate primary and secondary claims, which may differ in lag time.
- Schedule these reports for weekly delivery to the denial prevention team.

Add claim editing tools to:

- Create payer-specific edits to stop claims for review based on date of submission vs. date of service.
- Create an edit to review for duplicate claims.

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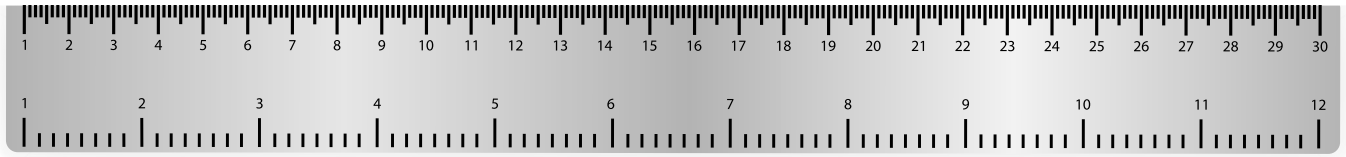
Apply 1 measure of success



The best part of implementing any new process is seeing and celebrating the results! We recommend setting one goal for success to ensure consistent measurement and motivation. Three common measures include:

- **Denial Rate**
- **Clean Claim Rate**
- **Days in A/R**

We prefer to use clean claim rate — the proportion of claims successfully submitted and reimbursed without requiring manual intervention — because it's easy to measure and is more proactive than measuring denials downstream. That said, when you first begin tackling denial prevention your clean claim rate may drop temporarily as you move issues up from the back end of the revenue cycle. As you adopt and automate new edits and processes, you should see the clean-claim rate continue to improve.

Clean claims = **fewer** denials

To make sure you're measuring denials consistently **use HFMA's Map Keys as a guide.**

Don't forget to celebrate your success!
Whether it's through a vendor's success program, social media, or a pizza party, recognition can help your team stay motivated to achieve their goals.

Benchmarking Clean Claims

Category	Target
High performing	98% - 99%
Pushing the envelope	96% - 98%
Solid performance	90% - 95%
Looking to improve	< 90%

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Example

Just small improvements to your organization's clean claim rate can lead to huge savings. We've rounded from our client example to simplify the math, but use your own monthly claim volume to apply this to your organization:

10,000 claims/month **x 90%** clean claim rate **= 1,000** claims to be reworked, or **$25,000**/month*

10,000 claims/month **x 91%** clean claim rate **= 900** claims to be reworked, or **$22,500**/month

$25,000 – $22,500 = $2,250/month

$2,500 x 12 months **= $30,000** annual savings for each percentage improvement

Whether your office bills more or fewer claims than this, the results are proportionate.

**Assuming $25 per claim to rework[1] — this is likely conservative as data is from 2014.*

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Your partner in prevention

Availity Essentials Pro is Availity's premium, all-payer clearinghouse empowering some of the nation's largest hospitals and health systems with revenue cycle automation, AI, and expert client consultation.

Our Client Success Managers have deep experience helping providers across the country meet their business objectives and optimize their systems to get paid faster and more accurately. Through proactive support, regular touchpoints, and strategic planning, CSMs help clients achieve results like:

- Reduced time to adjudication by **41%**
- Decreased in-house paper claims by **80%**
- Average **98.8%** clean claim rate
- **20%** reduction in staff dedicated to claim statusing

If your clearinghouse vendor is more "set it and forget it," you could be missing opportunities to do more with the staff you have. Get in touch today to find out what it's like to have a real revenue cycle partner with **Availity Essentials Pro**.

Availity essentials PRO

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References

[1] MGMA Resources: You might be losing thousands of dollars per month in 'unclean' claims, 2014. https://www.mgma.com/resources/revenue-cycle/you-might-be-losing-thousands-of-dollars-per-month

[2] MGMA Resources, 4 keys to driving down denials, 2018. https://www.mgma.com/resources/revenue-cycle/4-keys-to-driving-down-denials

[3] JAMA, Waste in the US Health Care System: Estimated Costs and Potential for Savings, 2019. https://pubmed.ncbi.nlm.nih.gov/31589283/

About Availity

Availity is the place where healthcare finds the answers needed to shift focus back to patient care. We work to solve communication challenges in healthcare by creating a richer, more transparent exchange of information among health plans, providers, and technology partners. As one of the nation's largest health information networks, Availity facilitates billions of clinical, administrative, and financial transactions annually. Our suite of dynamic products, built on a powerful, intelligent platform, enables real-time collaboration for success in a competitive, value-based care environment.

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