

END-TO-END APPROACH TO DENIAL MANAGEMENT

Accelerates Cash Flow, Boost Collections

RICHARD C.H. MASSON, MBA, MHA

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

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In the past, many radiology groups didn't give much thought to their revenue cycle. They assumed that low A/R days and a high net collection percentage accurately reflected a healthy billing process. And if a denied claim fell below a specific dollar threshold, they simply wrote it off.

But as reimbursements continue to decrease and payor regulations multiply, radiology groups are finding themselves scrambling to adapt to an increasingly harsh economic environment. In today's market, only those groups that take every available step to ensure that they're being paid fully and promptly for services rendered can hope to prosper in the long run.

PRO-ACTIVE DENIAL MANAGEMENT

At the heart of a more rigorous approach to revenue cycle management is a process for dealing effectively with denials. Revenue leakage stemming from a below average or outdated process can average between 3-and-5 percent of total collections for many practices. It is therefore critical that groups develop end-to-end systems that can simultaneously reduce the likelihood of denials in the first place and also address them promptly when they do occur.

This combination of proactive safeguards on the front-end and consistent, back-end remediation steps – along with the diligent monitoring of contracted payor rates – creates a solid financial footing for radiology practices by reducing write-offs and increasing collections. It also allows practice managers to more quickly isolate recurring problems in coding and documentation and immediately bring these issues to the attention of the responsible party or parties.

TYPES OF DENIALS

First, some terminology: Denials include any claim that is kicked back by the payor following a back-end edit. In contrast, a rejection is a claim that fails to get through a front-end edit. According to industry experts, 30 percent of total claims filed are denied, although any rate over 10 percent should be reviewed closely.

COMMON TYPES OF DENIALS INCLUDE:

Type of Denials	Definition	Example	Percentage of Denials That Fall Into Each Category
Medical Necessity	This is a situation where the payor deemed the submitted diagnosis code information did not support the procedure	ICD-9 not reported to the 5th digit	18%
Procedure Bundling	These include situations where multiple CPT codes are reported that should be bundled into one CPT code per the CCI edits	S&I Code outside of the bundled time limit	11%
Duplicate Claims	These include claims that are re-sent by the practice due to inaction by the insurance company	Duplicate Chest X-ray	14%
No Prior Authorization	With this type of denial, the exam either wasn't authorized or the required authorization number wasn't entered into the system	Billed with contrast – authorized without contrast	13%
Untimely Filing	This means the physician or provider did not file within the number of days allowed under the payor contract	Have proof of timely submission but the claim is still denied untimely	10%
Non-Covered Services	These include services excluded from the payor contract or having multiple exams during a coverage period	Patient has more than one mammogram during the coverage period. This should be discussed with hospital admissions.	10%

*The percentages of denials listed are according to a March 2008 RBMA mini-survey. **The denials do not add up to 100% as only the six most common denials are listed.

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DEMOGRAPHIC INFORMATION

Effective denial management starts with detailed, accurate demographic information. Patient data provided by the hospital information system must be carefully organized in the billing system so that individual patient accounts can be sorted and accessed both by payor and plan, be it an HMO, PPO or high-deductible/health savings account.

Mapping patients to specific plan numbers can be a tedious and time-consuming process. In addition, regular reviews of the demographic maintenance tables are necessary to ensure ongoing accuracy. But the efforts will pay big dividends over the long run by allowing practices to quickly assess the status of all claims filed in conjunction with a particular managed care product. Patterns of denials or delays will become readily apparent and can be addressed individually or as a group.

The detailed tracking of patients by plan also can reveal unanticipated vulnerabilities in the billing process. For example, an increase in the number of self-pay patients can reflect hospital delays in entering patient information. Alternatively, a dramatic shift in the volume of a particular managed care product could be the result of a plan change made by a major employer. Since hospitals typically do not inform physician practices of plan changes made by employer groups, it is incumbent on the physician practice to identify these kinds of developments quickly in order to ensure that claims do not fall between the cracks.

DICTATED REPORTS

Prompt and accurate dictated reports received from the hospital likewise are a critical element in accurate claims submissions, since appropriate medical histories and medical necessity documentation are the lifeblood of proper coding. A mechanism should therefore be in place that allows coders to exchange feedback to the physician any documentation that is inaccurate or incomplete. This process will accelerate cash flow and – just as important – instill greater accountability, consistency and discipline among physicians when it comes to documentation requirements.

Quick and effective recognition of documentation problems necessarily requires that coders be thoroughly trained in the many nuances of radiology coding and be familiar with the required Local Coverage Determinations (LCDs) and other national standards such as the Correct Coding Initiative (CCI) edits to appropriately code imaging procedures. Whenever possible, coders should obtain a nationally recognized certification such as the Certified Procedural Coder (CPC) status, the Radiology Certified Coder (RCC), or the Certified Coding Specialist – Physician-Based (CCS-P) certification. In addition, specific audit programs should be in place and followed by the coders to ensure that their error rates remain at or below acceptable levels.

PAYOR SPECIFIC GUIDELINES

Populating the billing system with payor-specific guidelines helps prevent the submission of claims that will be denied for lack of medical necessity. In addition, payor and plan specific billing parameters – which define submission requirements and timelines for initial claims, re-filed claims, patient statements and pre-collection letters – should be inputted according to payor class.

Keeping this information current is critically important, given the increasing breadth and complexity of payor requirements. By regularly monitoring ever-changing payor rules regarding medical necessity and by ensuring that the billing system is populated with the most up-to-date submission requirements, groups can greatly reduce the number of claims that are denied as non-compliant.

A strong denial management system will catch most mistakes before the claim is submitted and immediately push requests for additional information back to the physician. In addition, electronic tools that incorporate Medicare guidelines, Correct Coding Initiative edits and LCDs can be loaded into the billing system to automatically generate alerts or flags when key data are missing or incorrect.

CLEARINGHOUSE REPORTS

Once the claim is submitted to the carrier, the next line of defense aimed at mitigating the impact of denials involves daily or weekly reports provided by the claims clearinghouse. In the past, physician groups often had to wait weeks before learning that a carrier had denied a particular claim. This delayed notification slowed cash flow and often made remediation difficult or impractical.

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Today, however, electronic connectivity between the carrier and clearinghouse has greatly accelerated the process of identifying denials resulting from improper diagnosis codes, incorrect policy numbers and other errors. Clearinghouses typically generate reports – usually on a daily or weekly basis – identifying those claims that were accepted for payment by the carrier and those that were denied. By monitoring these reports, practices can quickly identify denials and immediately route the claim to the appropriate staff to resolve the problem. Once again, it is important that information be collated by both carrier and carrier plan to expedite resolution of the denials. Some clearinghouses have taken claims automation a step further by harnessing the Internet to provide near-real time denial identification and remediation. Some of these applications, for example, allow practices to resolve minor errors – such as an incorrect policy number – online and thus avoid the time and effort involved in resubmitting the claim.

PENDING INSURANCE CLAIMS

All claims, whether submitted electronically or not, should be monitored closely until payment is made. Thus, the group's billing system should be set up to generate regular reports on the status of all outstanding claims. The system should allow for the inclusion of denial codes, denial appeal codes and detailed notes to ensure that the status of all claims and/or denials is understood and tracked.

Reviewing the Pending Unpaid Insurance Claims data can reveal larger patterns, such as an inordinate number of claims denied on a particular date of service or denied by a specific carrier or plan. Although many claims are now filed electronically and typically generate an electronic acknowledgement of receipt by the carrier to the clearinghouse, electronic submission is no guarantee for prompt payment. That's why it is important to monitor the Pending Unpaid Insurance Claims data to flag payments that are lagging. This is particularly true for some commercial and workers' compensation claims, as well as any claims that are not filed electronically.

BACK-END PROCESSES

By mapping patient accounts and claims to specific plans and carriers and incorporating detailed notes, denial codes and denial appeal codes in the system, practice managers are able to access a wealth of information about denial occurrences and trends.

For example, if a denial is appealed, a specific appeal code is added to the account. The billing system can then be queried to determine how many similar appeals have been made to a specific payor. This data shows the percentage of claims submitted to a specific carrier that are denied and/or appealed. This level of detail can prove invaluable during contract renegotiations.

Assuming the billing system has been set up correctly, detailed queries also can be extremely helpful in identifying internal impediments to an optimized revenue cycle. For example, denial patterns involving specific procedures or physicians become readily apparent. The mistakes or omissions that resulted in the denials can then be addressed.

PAYMENT VERIFICATION

Another key automation component involves confirming that payments made for specific procedures are consistent with the terms contracted with the payor. Fee schedules by carrier and plan are loaded into the system and flags are generated if the amounts paid are in variance with the schedule.

Aggregated reports that show multiple instances of incorrect payments are another important tool groups can use to ensure fair and equitable reimbursement. Carriers typically are more likely to respond to a report showing numerous deviations from the fee schedule than they would if the erroneous payments are presented to them individually.

IN-HOUSE OR OUTSOURCE?

Developing an end-to-end denial management system is not a simple task. It requires commitment, resources and cooperation across the physician practice. Groups must therefore carefully weigh the costs and benefits of establishing a denial management system internally versus contracting with a billing vendor capable of providing a complete array of denial management services.

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Regardless of the course that's ultimately taken, one fact is clear: Most radiology groups can no longer afford to accept the status quo when it comes to revenue cycle management. Without a robust and comprehensive mechanism capable of minimizing denials and resolving them quickly when they do occur, radiology groups are operating at a distinct competitive disadvantage versus both carriers and other practices. Only by systematically managing denials to maximize and accelerate cash flow can groups hope to survive the difficult economic times ahead.

Richard C.H. Masson, MBA, MHA is the Vice President of Operations for MMP's South Region. He leads a team of professionals responsible for process and operations management solutions for radiology, anesthesia and emergency medicine practices, bringing over 15 years of healthcare experience to the company.

Mr. Masson joined MMP in 2000. Prior to joining MMP, Mr. Masson was the General Manager overseeing the Georgia radiology operations of a national medical management firm. Mr. Masson is a member of the Radiology Business Management Association.

Mr. Masson graduated from the University of North Carolina at Chapel Hill with a degree in international studies and received his Master of Business Administration and Master of Health Administration at Georgia State University.

About MMP

Based in Chattanooga, Tennessee, MMP has more than 80 offices and 2,000 employees nationwide. Founded in 1993, MMP serves more than 3,000 hospital-based physicians across the nation and boasts the highest client retention rate in the industry.

For additional information please call **1.866.310.4600** or email radiology@cbizmmp.com.