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WHITE PAPER

Confronting Complex Claim Denials: A Healthcare Provider's Guide to Managing Denials

Introduction

Although some denials are inevitable, most — up to 90% — are avoidable.

For the majority of healthcare providers, claim denials are a constant source of risk. Findings have shown that out of $3 trillion in medical claims submitted by hospitals in the United States, $262 billion of those charges were initially denied[1]. Even though 63% of those claims were recoverable, it still came with a cost of $118 per claim, or as much as $8.6 billion in appeals-related administrative costs. Carrying the burden of these denials and associated expenses, healthcare organizations are potentially writing off millions of dollars each year. As the primary source of revenue for most hospitals and health systems, getting claims processed accurately and efficiently is essential to a provider's financial health.

Complex claims are **4x more expensive** to process than the initial claim

Reworking denied claims costs as much as **20% of revenue** cycle expenses

37% of denied claims **remain uncollected**

[1] RevCycle Intelligence, 2017.

A denied claim is not just an interruption in cash flow, but also an increase in manual effort as staff needs to dedicate added time to investigate, appeal, and track each claim. Exacerbating the problem is the rising cost of reworking denied claims, estimated to be as high as 20% of an organization's revenue cycle expenses — or four times more expensive to process, on average, than the initial claim[2].

The latest Advisory Board's benchmarking survey revealed the median cost to collect increased to 3.3% net patient revenue, the highest it has been since 2013. With these costs outpacing revenue growth[3], denials management and mitigation has emerged as a key revenue cycle priority — and healthcare organizations must keep costs in check to sustain a healthy bottom line.

To this end, it is vital to adopt a preventive and holistic approach to denials management; one that leverages actionable insights for continuous process improvement, especially in light of continually changing standards, regulations, and reasons claims are denied by payers. Although some denials are inevitable, most — up to 90% — are avoidable[4].

This means employing a preventive denials management strategy, to reduce claim denials and increase clean claims, is immediately beneficial to healthcare providers — and, more importantly, remains sustainable in the long term.

[2] Healthcare Financial Management Association, 2021. Ensuring the Revenue Cycle Gets a Clean Bill of Health.
[3] Healthcare Financial Management Association, 2021.
[4] Advisory Board, 2014.

Getting ahead of denials

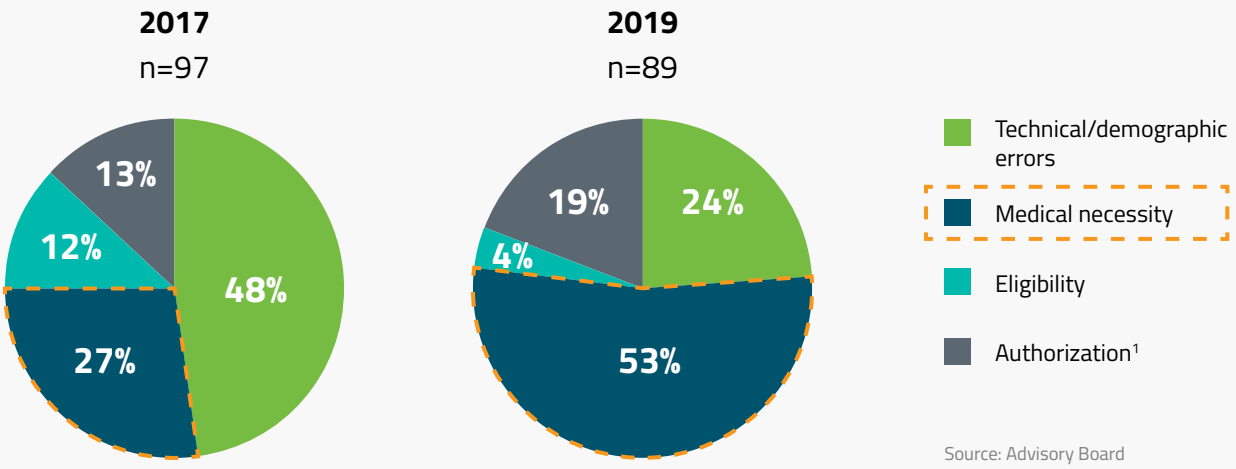
Before an unprecedented global pandemic changed the face of healthcare delivery and disrupted revenue cycle operations, the reason for initial denials and denial write-offs signaled a substantial shift.

While technical and demographic reasons are unfortunately common, making up a large number of denials, they too often shift time, focus, and work efforts from more viable claims, to the laborious correcting and resubmitting of claims back to the payer for reconsideration.

However, this was replaced by a clinical crisis, with denials due to medical necessity growing at the highest rate in over decade of benchmarking[5]. The study also revealed the increase of medical necessity denials across all payer categories, whereas historically it was derived from one subset of the payer population.

[5] Advisory Board, 2019. Hospital Revenue Cycle Benchmarking Survey.

Denial write-offs, by reason



Source: Advisory Board

The full impact of the Covid-19 pandemic remains to be seen, but in a new normal that introduced a new level of intricacy to claim processing — including a growing uninsured and under-insured patient population, new payer rules around virtual care, and new billing codes released at a "blink-and-you'll-miss-them" rate[6] — adopting a preventive strategy to reduce denials and increase clean claims is more important than ever.

So, how can healthcare providers pursue complex denials effectively and efficiently? Traditionally, there are two ways healthcare organizations have gone about this.

Some organizations may prioritize moving claims out the door as quickly as possible, and then mobilizing follow-up staff to handle denials and the resulting rejections. Others may put more focus on every claim at the billing stage to head off the potential for follow-up work down the road. However, without a specialized and dedicated team equipped with intelligent automation tools and the expertise to use them effectively, both approaches involve time-consuming, resource-intensive, and exhaustive manual efforts that balloons the cost of claim management.

[6] Healthcare Financial Management Association, 2021.

4 ways healthcare providers can lower claim denial rates

A sustainable, preventive approach to claims management entails four steps:

1 Identify denials as early as possible.

The earlier a hospital identifies denials, the greater chance they have to resolve the issue. However, hospitals still struggle to identify denials early enough to be effective. This could be due to lack of technology, resources, or not being familiar with coding from the payer.

As a solution, hospitals should develop a clear understanding of types of denials, such as technical and medical necessity, and categorize them in a way that is logistically easy to understand. This ensures that accounts are routed appropriately, and claims don't stay in accounts receivable too long, in order to adhere to a timely appeals process.

Letting accounts age in receivables too long, as new denials continue to come in, creates a snowball effect that buries the provider's ability and/or right to appeal the denial. To identify denials in a timely manner, healthcare providers should dedicate specialized resources to the task and invest in software to capture and automate denial identification and categorization.

KEY TAKEAWAY

Move denied claims out of A/R within 30 days before the right to appeal is lost.

2 Track appeals and build on successes.

Keeping an eye on each denial appeal, and tracking to see if it is successful, does more than gauge the effectiveness of your denials management process — it also provides actionable insights that healthcare providers can build upon.

One of the core mistakes that healthcare providers make when pursuing denied claims is approaching appeals in a fragmented, disconnected environment. Instead, providers should keep track of which payers they are having success with, which appeal strategies were successful with those payers, **and identify the accounts that are denying with that payer with the same issue**.

By leveraging a systematic reporting methodology, the whole organization benefits from the collective knowledge that would otherwise be siloed and dependent on only a few experts.

KEY TAKEAWAY

Classify denied claims accurately and use data to identify trends across similar accounts. Appealing claims for medical necessity, for example, requires having the full knowledge of local and national coverage determination policies.

3 Enable employees to build appeals expertise.

Hospitals may have employees who work on claim denials but also have other job functions besides appeals. Instead, hospitals should optimize those working claims, allow them to become a subject matter expert in that area, and enable employees to build a knowledge base from what they've learned.

Having a system in place to record collective knowledge — and making it easily accessible — also ensures that the knowledge gained stays within the organization in the event an employee resigns, takes a vacation, or falls sick.

KEY TAKEAWAY

Dedicate staff members to focus primarily on dealing with appeals and establishing processes that streamline complex denials.

4 Bring in non-traditional hospital employees.

Healthcare providers should not be afraid to consider non-traditional hospital employees, such as a paralegal or attorney, to help with the denial appeal process. As appeals essentially involve advocating for the hospital, it is important to employ non-traditional staff with the training and out-of-the-box thinking necessary to craft an argument in a light most favorable to the patient and the hospital to compel the insurance company to indemnify the patient. Non-traditional hospital employees may give your business office additional resources that healthcare providers traditionally do not have access to.

KEY TAKEAWAY

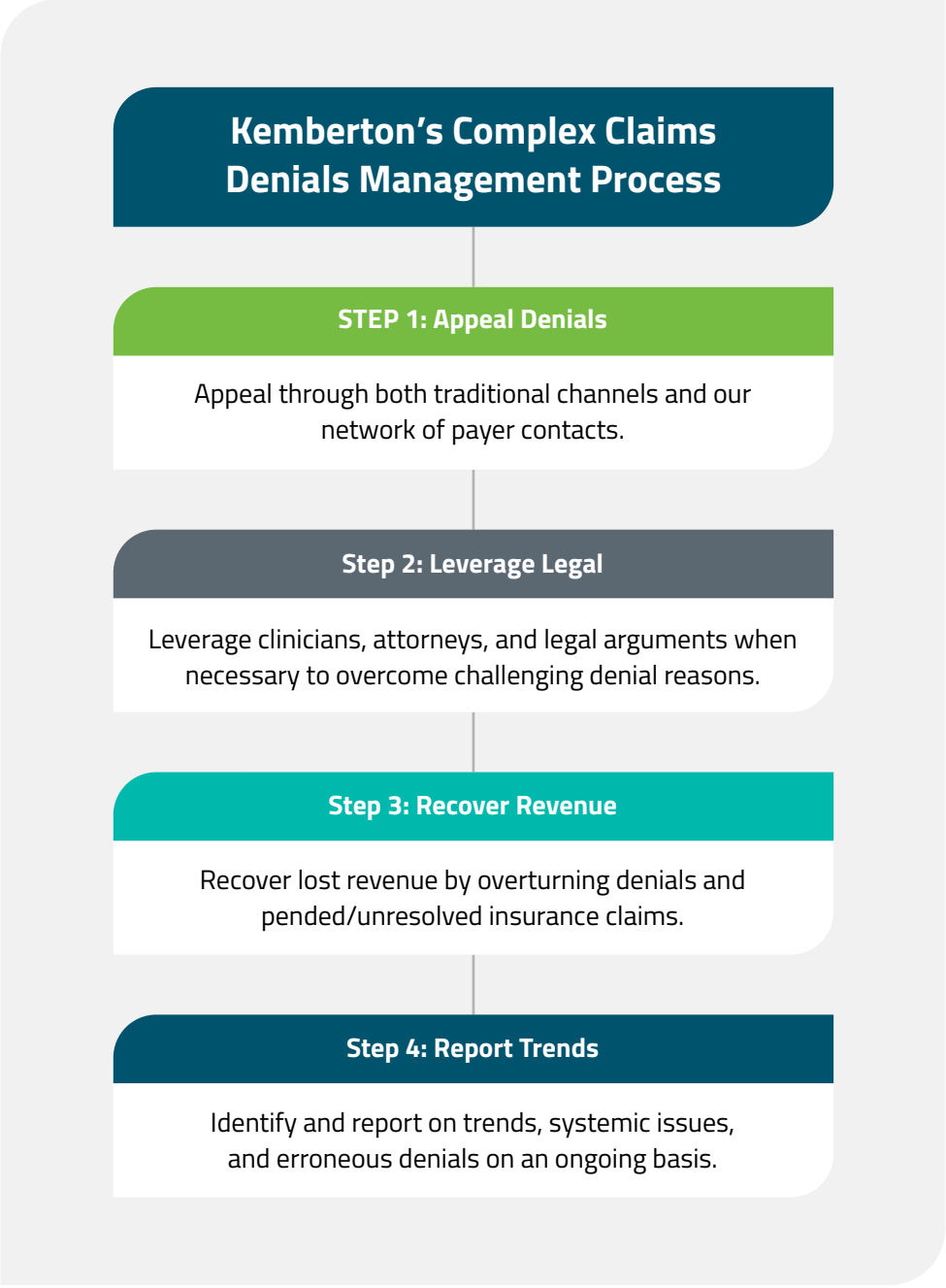
Employ people of non-traditional backgrounds such as paralegals or attorneys who will advocate for the provider and the patient.

Why outsource complex claims denials management?

The increasing volume and complexity of denials make it a moving target that most healthcare providers cannot effectively pursue without an enormous drain of time and resources. Although hospitals may try to reduce denials by going upstream — putting in place clinical documentation programs to address medical necessities — the challenges continue to grow as the complexity of getting the denial overturned becomes much greater. At the same time, organizations need to identify, appeal, and track the constant stream of new denials adversely impacting receivables.

Revenue cycle management technology has been playing an ever-increasing role in collecting on some of the more complicated claims, but the technology is only as effective as the people who are in place once the system has identified the denials. The only way to give it justice is to have a dedicated team of trained professionals tackling these complex claims.

When you engage a specialized RCM partner like Kemberton, you benefit from the experience and expertise of a dedicated team of attorneys, clinicians, paralegals, and denials analysts. Because denials are so specialized in nature, having specialized resources — dedicated to investigating and advocating on behalf of patients and hospitals — is key to the success of your denials management and prevention strategies.



90%+
average collections of pursuable charges

400+
hospitals served

1M+
claims processed annually

$500M+
payments facilitated annually

Why Kemberton?

Kemberton's experienced team of attorneys, clinicians, paralegals, and denials analysts specialize in complex claims denials, advocating on behalf of providers and patients — and turning historically written-off dollars into cash. Once the provider's efforts to overturn denied claims are exhausted, we seamlessly take over the process and get to work. By leveraging our years of experience and network of payer contacts, we deliver significant cash increases to providers across the country by getting denied claims overturned and paid.

Partnering with Kemberton enables healthcare providers to efficiently pursue complex claims denials by:

- Allocating resources to claims that require a higher level of critical thinking and activity to resolve
- Leveraging impactful appeal arguments for each payer across a broad spectrum of providers and coverage scenarios resulting in successful outcomes
- Gaining access to non-traditional hospital employees like experienced paralegals and attorneys

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