Refreshing denial management: Targeting trends with data and collaboration

Hospitals have made avoiding and managing denials a top priority, but for many their best efforts have yet to turn the tide. The quest to get ahead of denials and protect revenue has gained urgency as hospitals continue to cope with the financial impact of the COVID-19 pandemic.

With budget cuts and staffing shortages (see related article on p. 31) putting pressure on revenue integrity departments, denial management solutions can feel out of reach. But with knowledge, data analytics, and an organized strategy, revenue integrity professionals can address issues at their root and reduce denials.

Rising rates

The average rate of denials rose 23% from 2016 to 2020, according to a 2021 Change Healthcare *report*. Even after the onset of the pandemic, denials continued to rise—particularly in areas hardest hit by the first wave. Yet 86% of denials are avoidable, according to the report.

In June 2021, HealthLeaders *reported* that 33% of hospital executives said their average denial rates are more than 10%.

The rise in denials isn't surprising given the increasing complexity of reimbursement rules, says **Monica DuBois, RHIA,** vice president of coding solution technology at DeliverHealth in Atlanta. Pandemic-related changes in rules and staffing added fuel to the fire.

"Everything blew up in 2020," DuBois says. "There were so many changing rules, and now we're just starting to see some of those denials come through."

Current trends

So, what are some of the biggest denial pain points? Experts agree that most of the current denial targets feature familiar diagnoses: sepsis, malnutrition, acute kidney injury, acute tubular necrosis, and respiratory diagnoses.

Most of these diagnoses are based on clinical criteria, and there may be differences in the criteria used by providers, payers, and third-party auditors, says **Melissa Rodriguez, CCDS, CDIP, CCS, CCS-P, CHRI, CPMA,** manager of clinical denial solutions at Enjoin.

Payers are taking a harder look at any claim with a respiratory, sepsis, or COVID-19-related diagnosis. More than 25% of audits are related to these diagnoses, according to **Dawn Crump, MA, SSBB, CHC,** senior consultant for revenue cycle solutions with MRO Solutions in Norristown, Pennsylvania.

Organizations should keep a close eye on COVID-19 denials, particularly from commercial payers, DuBois agrees. Commercial payers might have specific coding guidance, for example, that differs from CMS'. If an organization doesn't take that into account and coders aren't trained on these payers' rules, denials will start to rack up, she says.

Other areas to watch are behavioral health and telehealth, according to Crump. Issues around proper use of new vs. established patient evaluation and management codes aren't new, but the expansion of telehealth during the pandemic added a fresh wrinkle. New codes and guidelines needed to be learned and applied quickly.

"We're addressing risks whenever there are any telehealth codes and allowing internal auditors visibility, making sure that those codes are utilized and coded appropriately," Crump says.

Along with an uptick in denials, many hospitals are seeing a rise in pre-payment audits, or even a general shift in that direction, Crump adds. Pre-payment audits can be difficult to manage and track because they're generally handled by staff who aren't part of established denial management teams.

"Many of our providers have seen an over 200% increase in shift from post-payment to pre-payment audits," Crump says. "[This] is impacting accounts receivable and audit oversight."

Keeping an eye on top denial targets ensures you can focus resources, manage denials, and get closer to root causes. But resolving and avoiding denials calls for tailored approaches and careful planning.

Meeting clinical criteria

For clinical validation denials, payers will often cite clinical criteria. It can be particularly difficult to challenge these denials, and payers and their third-party auditors are pushing back harder than ever, Rodriguez says. An appeal letter may include thorough documentation and strong, evidence-based references to support the diagnosis, but the denial could still be upheld. Sometimes the payer references out-of-date criteria, or uses criteria of its own without publicizing what those criteria are, she explains.

"We find that it takes tracking all of these and then talking with the payer and showing the discrepancies in their methodology," Rodriguez says. "It's just taking a little bit more higher-level involvement in these denials to get them overturned. I think it's increasingly difficult to [overturn a denial with just] an appeal letter."

Adding a physician or physician advisor (PA) to the denials management team can help tip the scales, she adds. A physician or PA brings the highest level of clinical expertise to the discussion and

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a greater insight to conversations with payers' medical directors.

But sometimes the documentation truly doesn't support the diagnosis. Despite robust education and CDI programs, poor documentation continues to be a common root cause of denials, DuBois says. Over the past year, some organizations eased off physician education programs to focus much-needed resources on patient care. However, pulling back too much only creates work in the middle- and back-end revenue cycle while leaving clinical staff out of the loop and disengaged when education picks up again.

"Given the demands [clinical staff are] dealing with, I think it's important to partner with them, educating and reeducating them in ways that are most engaging and personal," DuBois says.

Rather than pulling physicians into a classroom, meet them on their turf, DuBois recommends. At one organization, DuBois conducted training in the physicians' office. The physicians were more engaged and receptive in that environment, rather than feeling they were being pulled away from their work.

However, the pressure of real-world situations means physicians will always be dividing their attention between patient care and documentation. Adding medical scribes can help take that burden off clinical staff, according to DuBois. Medical scribes are trained to focus specifically on documentation, leaving clinical staff free to devote their attention to patients.

Branching out

Interdepartmental denials management teams aren't new. Typically comprised of representatives from revenue integrity, HIM/coding, billing, and CDI, these teams take a cross-functional approach to manage denials and appeals and conduct root cause analysis. Like many traditional revenue cycle initiatives, they generally focus on Medicare. However, DuBois notes that reactive, Medicare-focused teams may find themselves struggling to adapt as payer mixes change, the Medicare Advantage population grows, and commercial payers adopt more aggressive denial stances.

Modernize denials management by looping in payer contracting, DuBois recommends. Payer contracting staff can provide insight and education on the details of contracts that govern issues such as denial response times and payer-specific coding requirements. They may also be

able to facilitate feedback between the provider and payer organizations. Keeping them updated on how contracts perform will be invaluable when those contracts are up for renewal.

Payer contracting staff are key players in contemporary denials management, Rodriguez agrees. As the Medicare Advantage and commercial payer populations evolve, organizations must adapt to the new landscape. Start by comparing payer denial activity to contract terms and identifying anything that doesn't match up.

For example, Rodriguez recently worked with an organization that saw one payer consistently deny claims for sepsis. The payer's sepsis criteria were clearly stated in the contract. After reviewing the documentation, Rodriguez determined that the organization was successfully following the criteria.

At that time, the organization's HIM department and payer contracting department didn't have a strong connection. Rodriguez reached out to the payer contracting department to bring them into the team.

Once the entire group was on the same page, they were able to gain a complete picture of how much reimbursement was being lost to these specific denials. That information was then presented to the payer, along with the contract language defining the sepsis criteria. The payer agreed that the claims shouldn't have been denied. It was eventually discovered that the payer had failed to communicate the appropriate sepsis criteria to the third-party reviewer.

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"If it hadn't been tracked and [if there hadn't been] a conversation with that payer, then that money would have been lost," Rodriguez says. "You need to have some sort of mechanism to track whether the contract requirements are being met and then following up."

Sharing data with payers, such as denial trends, can go a long way to building a productive partnership, says **James P. Fee, MD, CCS, CCDS,** CEO of Enjoin. However, focusing solely on denials—a situation where one party must have made a mistake—can create a negative atmosphere and slow down efforts to reach a resolution. Instead, present data comparing denials to paid claims with the same diagnoses and services. Then, involve the payer in a conversation based on mutual education and information sharing.

"Show them the data of what is denied and take that exact same case or population that has not been denied," Fee says. "What are the differences between them? [Ask the payer to help you] understand how to bridge this gap. What am I doing wrong in this bucket as opposed to what am I doing right in this bucket?"

However, there may be cases where the payer isn't willing to budge even when presented with evidence and offered an opportunity to collaborate, Fee adds. In these instances, it may be necessary to involve legal teams and explore broader patient advocacy tactics.

A proactive future

What will denials look like over the next year? Organizations will likely see the same familiar diagnoses—sepsis, malnutrition, respiratory failure—although the top diagnoses and volumes may be a moving target. But that doesn't mean that old, reactive methods will cut it, Crump says.

"What are we doing to come to a consensus on diagnosis documentation criteria or push back on the payers' reviews in a systematic way? If clinicians have a

difference in opinion from payers and neither changes their stance, then we're forever going to have denials on these common issues like sepsis," she says.

Instead, work to identify criteria and share data. Collaborate with your payer contracting teams to work through issues in formal payer reviews when trends arise. Then, use that data to guide internal audits that will help put lessons learned into action and prevent future denials, Crump adds.

Denials management is still a largely reactive, manual, resource-intensive process, DuBois points out. Widespread staffing shortages are putting even more strain on these processes. Moving to proactive and predictive denial avoidance processes will greatly alleviate these burdens, but that

change won't happen overnight. However, even small steps will eventually steer a denial management program from reactive to proactive.

"It takes an initial investment to get there," DuBois says. "I've seen [organizations] taking the approach of looking at it through the eye of data analytics and understanding that they have to get to the root of the problem."

Wider application of technology, such as augmented intelligence–powered business analytic products, is a game-changer, DuBois adds. In addition, staff can deploy their skills more effectively by moving from a retrospective audit approach to a prospective, focused approach and applying a rules engine with both global and customized rules

to identify potential issues in a focused manner before the codes are sent to billing.

Ultimately, all solutions must center around the patient, Fee says. Sound documentation is an extension of clinical best practice, and appropriate coding and billing ensures the patient is protected from unnecessary financial burden. When provider organizations ensure patients and quality of care are the driving factors across departments—from clinical to financial—they will be better positioned to ensure these best practices are upheld.

"Establishing best practice, both clinical and financial, will create a united front supported by legal precedents to defend against any payer disruption," Fee says. NJ