Denial Prevention: The Key to a Successful Revenue Cycle

Proactively addressing issues to maximize revenue and reduce turnaround times

CONIFER HEALTH SOLUTIONS®

For the past two years, physician practice expenses have continued an upward trajectory while staffing levels continue to drop. Total direct per-physician expense increased 14.2% in the first quarter of 2023 compared to the first quarter of 2022, and support staff FTEs declined 4.1% between the first quarter of 2022 and the fourth quarter of 2022.[1] In other words, practices are being required to do more with less.

Because these trends are expected to continue, practices need to be hyper-vigilant when it comes to preventing unnecessary revenue loss. The best place to start is with denied claims. A recent survey indicates that denial issues have escalated and are now a top concern for revenue cycle leaders, with 30% saying their organization's denials have increased between 10% and 15% over previous years. Another poll found those numbers to be even higher, with 69% of healthcare leaders reporting an increase in denials with an average increase being 17%.[2]

Top Denial Reasons Per Surveyed Revenue Cycle Leaders[3]

62%
Insufficient data analytics

61%
Claims and/or denials process lacks automation

46%
Lack of thorough training

Today, most practices address denials reactively after they happen. So, instead of taking steps to prevent denial-related revenue loss on the front end, they spend unnecessary effort recovering revenue on the back end. The latter is a costly, resource-intensive process, which is especially problematic given our industry's current labor shortage. The average cost to rework a single claim is estimated to be $25.20.[4]

> Research indicates that 86% of denied claims are preventable, and 48% are not recoverable.

The answer to effectively preventing revenue loss from denials is to implement the following three-pronged approach: Shore up front-end processes, create a high-performing denial prevention team and automate back-end processes.

Shore Up Front-End Processes to Improve Data Integrity

Data capture during the front end of the revenue cycle is one of the most underutilized processes in healthcare. Many practices rely on patients themselves as their primary source of data capture. Yet, patients often find their coverage information difficult to understand and sometimes forget about secondary or tertiary insurance altogether. It is common for practices to require patients to show up 15 to 30 minutes early to fill out insurance paperwork. This can frustrate patients and often results in partially completed or inaccurate information.

Even eligibility verification technology can have mixed results. Requiring staff to comb through 15 pages of coverage information is an ineffective use of their time, and the data returned is often outdated and incomplete and still requires additional work to validate.

One of the best ways to prevent denials on the front end is by gathering coverage information before a patient arrives. This alleviates the burden on busy front-desk staff, who are typically tasked with manually entering a patient's insurance card information into the system. Capturing this information at the time of scheduling also enables the practice to collect payment up front.

> Providers have only a 30% chance of collecting a patient's financial responsibility after the patient has checked out.[5]

Another way practices can prevent denials during front-end processes is through the use of robotic process automation (RPA). RPA works by mimicking human tasks through rules-based actions, allowing the technology to perform transactions and complete repetitive processes without human intervention.[6] RPA technology can streamline pre-service or real-time eligibility verification and coverage discovery. The technology can also proactively identify requirements for prior authorizations and the need for additional documentation, which can reduce delays in care and delayed reimbursement, in addition to reducing denials.

Create a High-Performing Denial Prevention Team to Improve Coding Quality

Ensuring claims are accurate and complete when submitted is vital to a practice's bottom line. Yet, this has become increasingly challenging due to the growing complexity of coding and documentation; just staying up to date on new codes can be difficult. This is why it is crucial that practices conduct rigorous and ongoing education for both new and seasoned coding staff. Coders should also be required to maintain certification and to complete continuing education credits regularly.

Because payers are denying record numbers of claims, practices must prioritize staying on top of payer requirements, especially those that apply to prior authorizations, medical necessity, and timely filing. It can be helpful to assign specific staff to own a particular payer or set of payers.

Practices should also consider implementing claim-scrubbing technology that filters, and flags claims with potential issues like missing or incomplete information so the claim can be fixed and resubmitted before hitting the payer's adjudication system. This can also help improve the productivity and quality of the coding staff.

Time-Consuming Steps in the Appeals Process

Call payers to reduce confusion around denial codes

Contact the insurance company to gather and record reference numbers

Gather all necessary and corrected documentation and patient information

Obtain and complete all required forms

Create and send appeal letters to address relevant issues (i.e., invalid code, incorrect name, modifier)

Resubmit appeals that did not include all the necessary documentation or patient information

Monitor appeals for updates/status

Automate Back-End Processes for More Effective, Touchless Denial Management

The good news is that two out of every three denials are recoverable, although 40% are never resubmitted.[7] This is primarily due to the considerable effort needed to research a denied claim and gather supportive documentation to support the appeal. Reworking denials is also costly, estimated at up to $181 per appeal. Therefore, many practices choose to appeal only the highest-value denials. However, this practice leaves much-needed smaller amounts on the table—amounts that can add up over the year.

One of the best ways to streamline denial management on the back end is through technologies that can provide in-depth root-cause analysis and identify more systemic patterns. These technologies help practices better understand which denials to prioritize and what steps must be taken to ensure a successful appeal.

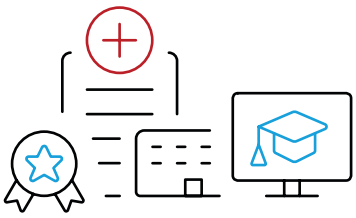
> Denials can vary in their likelihood of being successfully appealed. Technologies like artificial intelligence (AI) can predict which denials are most likely to be overturned and what steps practices need to take to make that happen.

Practices should also consider implementing technology that automates the actual appeals process. Again, RPA can be helpful, especially for bulk denials from a single payer. By automating these highly manual processes, practices may be able to reassign some staff to more patient-centered or strategic endeavors.

Leveraging technology to automate the appeals process can also be helpful, especially for bulk denials from a single payer. Automating this process helps reduce payment delays and improve appeals success. These technologies can enhance productivity without adding additional staff. In many cases, existing staff can be reassigned to more strategic tasks like escalation.

Creating the necessary infrastructure needed to streamline revenue cycle processes to prevent denials and improve the appeals process can be challenging, which is why many practices choose to partner with revenue cycle experts for help. Conifer Health is a great choice. Conifer has extensive expertise in managing payer relationships and conducts monthly payer meetings to discuss issues and proactively identify resolutions. For example, uncovering an issue with claim adjudication can help determine when to uphold or down-code appeals. This type of revenue-generating intervention can be challenging for practices to achieve on their own.

Success Story



A Chicago-based health system consistently ranked as a Top 15 Teaching Hospital in the U.S. and offers a significant footprint in the Chicagoland area.

Having grown through multiple acquisitions, the health system found itself with several different practice management systems and vendors. The organization decided to bring all its facilities onto the same Epic platform to streamline its revenue cycle efforts and create a more unified patient experience across the health system. In addition to this effort, the organization wanted to increase the value of its long-term revenue cycle partnerships.

The health system chose to extend its existing 21-year revenue cycle management relationship with Conifer Health and to leverage the vendor's extensive Epic expertise to help with the transition, which will begin in mid-2025. Conifer Health currently provides coding, claims management, denial management, payment posting, and cash reconciliation services for five of the health system's hospitals. Those services will soon be expanded to include the health system's latest acquisitions.

The expanded relationship with Conifer Health is a testament to the vendor's impact on improving the health system's revenue cycle. One of the most valuable aspects of the relationship is Conifer's expansive reporting capability, which has been instrumental in the organization's ability to optimize its revenue cycle. This includes:

- Increased and accelerated collections
- Reduced days in A/R
- Lower initial denial rate
- Reduced no-response A/R

The senior vice president of revenue cycle management at the health system's newly acquired hospital says, "We are excited to begin working with long-term revenue cycle partner Conifer Health, and we look forward to accomplishing great things together."

Three Steps in the Right Direction

In these challenging times, practices need to do all they can to collect every dollar they are owed at the lowest possible cost to collect. By leveraging this three-pronged approach, they can do just that.

Key Takeaways

- Skyrocketing expenses and a tight labor market continue to plague physician practices
- Denied claims have become a top concern of revenue cycle leaders
- The primary reason for denials is poor data integrity and a lack of data analytics
- Practices can proactively reduce denials through a three-pronged approach:
  - Shore up front-end processes to improve data integrity
  - Create a high-performing denial prevention team to improve coding quality
  - Automate back-end processes for more effective touchless denial management
- Partnering with revenue cycle experts can help

Sources

1. https://www.medicaleconomics.com/view/expenses-up-for-physicians-offices-hospitals-in-march
2. https://www.mgma.com/mgma-stats/6-keys-to-addressing-denials-in-your-medical-practice-s-revenue-cycle
3. https://www.experian.com/healthcare/resources-insights/thought-leadership/white-papers-insights/state-claims-report
4. https://www.mgma.com/mgma-stats/6-keys-to-addressing-denials-in-your-medical-practice-s-revenue-cycle
5. https://www.hfma.org/revenue-cycle/financial-counseling/61208/
6. https://revcycleintelligence.com/news/high-impact-robotic-process-automation-use-cases-for-the-revenue-cycle
7. https://journal.ahima.org/page/claims-denials-a-step-by-step-approach-to-resolution
8. https://journal.ahima.org/page/claims-denials-a-step-by-step-approach-to-resolution
9. https://www.waystar.com/revenue-cycle-101-denial-and-appeal-management/