Reducing Claims Denials: Employing Quality Improvement and Collaboration with Payers

By Andria Jacobs, RN, MS, CEN, CPHQ, CCP

Executive Summary

How many compliance officers and auditors are completely satisfied with the claims-denial rate at their hospital or medical group? It's difficult to say with certainty, because there are no readily available statistics for the average claims-denial rate on the provider side. Yet it is probably safe to say that limiting denials and the resulting lost revenue is a growing issue for many providers. That's because payers of all kinds, from Medicare and Medicaid down to the smallest health plans, are deploying ever more effective methods of identifying and denying claims that do not conform to CMS billing guidelines and commercial-payer contracts. Improving billing quality and working with payers using the methods discussed here will reduce denials.

Providers that have not yet felt the squeeze from denied claims are likely to notice new pressure at some point. High-profile efforts by Medicare to recoup revenue are only in the beginning stages. CMS announced in July that its Medicare recovery audit contractor (RAC) program recovered almost a billion dollars from providers in six states over three years[1]. By law, a nationwide program must be implemented by Jan. 1, 2010. Although provider critiques of the program could lessen the financial impact[2], the program is apt to impact provider revenues. It is hard to say how severe the average impact will be, but CMS's assessment gives us some idea. CMS asserts that the pilot program had 'limited financial impact' on most providers. However, CMS's definition of 'limited'—less than 2.5 percent of Medicare revenue—is debatable in an era of declining reimbursements.

To improve denial rates, it helps to understand payer strategies for auditing claims and how technology (much of which is based on CMS methods) is improving payers' ability to identify inaccurate claims and deny them. With that knowledge, providers can devise and implement effective practices for limiting denials and retaining revenue. Typically, that comes down to effective monitoring of denials, tracking of appeals and improving relations with payers.

Technology Changes the Game

Technology is transforming the ways in which payers audit claims and identify billing errors. CMS and the large commercial payers and health plans have long used claims-auditing technology to review claims. Until recently, however, most small and medium-sized payers and health plans had no alternative to manual claims review, which limited claims auditing to only 5 to 10 percent of all claims received. Being manual, those audits were based on the auditor's individual knowledge. Nowadays, however, many smaller and medium-sized payers are using highly effective claims-auditing software based on the technology used by Medicare administrative contractors.

Claims-auditing technology enables payers to audit every claim against a database of millions of edits, thus identifying every discrepancy from standard billing practices. The technology is data driven, programmed to spot upcoding, unbundling, incorrect use of modifiers and other nonstandard billing. The software is 'intelligent' in the sense that it enables plans to compare every claim submitted by every provider against CMS edits and as well as the payer's own data. These systems also compare providers against all members of their peer group within and outside the health plan (allowing for an apples-to-apples comparison of any variety of specialist).

As for how the technology presents the results to payers, providers should know that automated claims-auditing applications place each provider somewhere along a bell-shaped curve. This distribution curve clearly demonstrates where each provider's billing practices place him or her. This method enables payers to easily spot providers whose billing practices do not match those of their peers. As we will see, outlying providers are subject to a much higher risk of scrutiny.

By evaluating 100 percent of every provider's claims against the millions of edits in CMS and against the health plan's specific contracts, the scope of standard,

[1] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the Three-Year Demonstration." Centers for Medicare and Medicaid Services. Accessed July 17, 2008, at http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf

[2] "House Democrats Request Government Accountability Office Review of Medicare Recovery Audit Contractor Program." Medical News Today. Accessed July 17, 2008, at http://www.medicalnewstoday.com/articles/115148.php. Also, see letter from U.S. Reps. John Dingell and Charles Rangel to Gene Dodaro, Acting Comptroller General of the United States. Accessed July 17, 2008, at http://energycommerce.house.gov/Press_110/110-ltr.071108.GAO.RAC.pdf

everyday claims audits has increased significantly across the payer spectrum. This has resulted in greater consistency and gives payers confidence that incorrect billing will be identified and denied.

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Increasing the Risk of Payer Scrutiny

As payers adopt increasingly effective claims-auditing applications, denied claims are becoming a bigger concern for providers. Although denied claims can result in lost revenue, there is another, even more unwelcome risk from inaccurate billing: the increased potential for payer scrutiny in the form of full-scale audits. Technology enables payers to categorize providers according to the frequency of their questionable billing practices, in addition to their rate of billing errors. Such outlying providers are at much higher risk of being audited. And as compliance officers and auditors on the provider side well know, audits are almost always a very expensive proposition.

Whether high in volume but low in dollar value or small in volume but high in dollar amount, billing errors increase the risk of scrutiny by payers. Claims-auditing technology gives payers the information they need to determine which providers to scrutinize: Software identifies providers according to a variety of billing errors, from the volume of errors to the dollar value, from overuse of certain codes to repeated denials for the same charges. Even though denied charges do not cost the payer (with the exception of administrative costs, which are not an insignificant expense), payers assume that error-prone providers are the most likely to have made billing errors that only a close review of the medical record can uncover. Another payer assumption is that these errors will, for the most part, be in the payer's favor.

Billing Accuracy: Answering a Growing Challenge

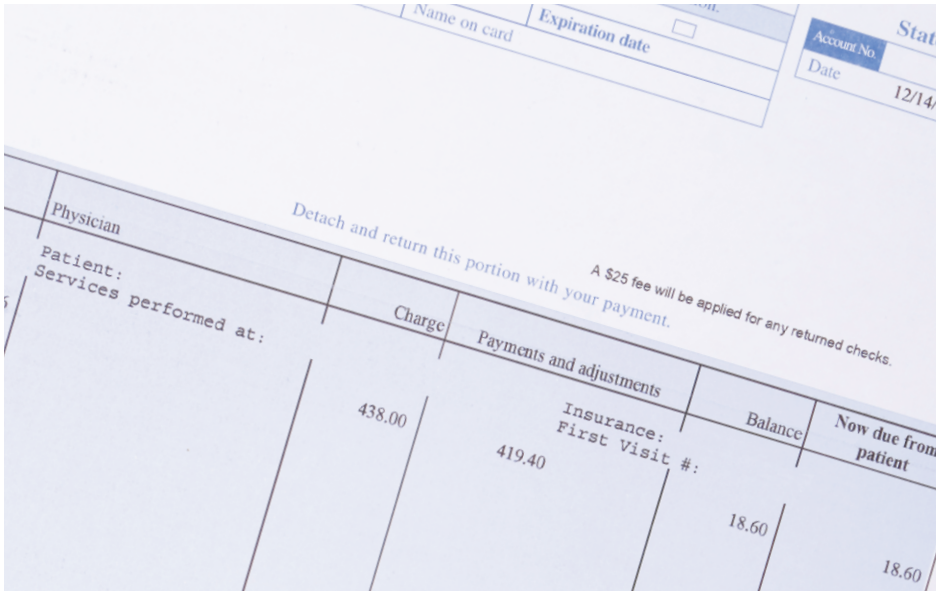
Naturally, providers that have low billing-error rates are less likely to be audited. The question is what are the best steps providers can take to ensure their billing is accurate? I think it is important to preface any discussion of ways providers can improve their billing accuracy and reduce denials by acknowledging that billing is a very demanding job which is getting harder all the time. It is a monumental task to keep up with voluminous amounts of payer instructions, understand and synthesize them, make the necessary changes to billing processes, communicate the changes to billing and clinical staff, and, to top it all off, monitor whether the changes have in fact been effectively, correctly implemented. Auditing claims before they are sent to payers and then monitoring the remittance advice sent back to the provider by payers is its own full-time job at any sizable medical group.

It is important for group physicians and management to understand the staffing conditions necessary for accurate, compliant billing practices that submit claims for and then actually receive all of the revenue the provider is owed. That means fielding a compliance and auditing staff commensurate with the volume of billing in addition to the billing staff. If group management fails to grasp this, it is incumbent on whoever leads the group's billing operations to demonstrate the need.

Adequate staffing and commitment from group management is a prerequisite to accomplishing the steps listed below. Yet even without adequate staffing, billing and compliance professionals reading this article can follow these steps insofar as possible and, by demonstrating to management the group's lack of resources to achieve accurate billing, make clear the need for enhanced resources.

Tracking Denials and Monitoring Appeals

The foundation of reining in denials and promoting accurate billing is having an effective system of tracking denials. Effective tracking allows providers to determine why claims are being denied and correct the billing errors that are identified in that process. No matter how a provider bills—whether manually, through an automated billing system or through a billing service—it is imperative that the provider assume the responsibility for effectively monitoring denials and determining which results from provider error and which come from payer mistakes. The seminal step here is to establish a denials reporting structure for each payer. Spreadsheets are a useful tool for gathering into a central place the details of each payer's denials. For providers that use automated billing systems (which must be updated quarterly) or billing services, it is imperative to run and analyze detailed denials reports.



Systematic tracking of denials might seem to be a painfully obvious measure that all but a very few providers already take. Yet if that were the case, it is doubtful that Medicare would make frequent reports detailing the services that providers persistently code incorrectly. After all, if all but a few providers tracked denials effectively, would it not stand to reason that they would correct the billing errors that lead to denials? The reality would seem to be much different, as evidenced by the Office of the Inspector General's 2008 semi-annual spring report. The report identified $1.1 billion in audit receivables; 40 percent of those billing errors were attributed to nine types of errors, such as office visits (Est. 99211), which had insufficient documentation in 12 percent of claims. Misuse of modifier -59, meanwhile, continues at a 40 percent error rate.

My own experience as a practice management consultant on the provider side and, today, working with payers as a technology vendor, is that many providers make the same billing errors over and over. Determining the provider's most persistent, repeated denials and prioritizing them based on frequency and value is a good way to begin reducing claims-denial rates. After ascertaining the reason for each denial (more on how to do that in the next section) and appealing or rebilling as appropriate, it's also essential to monitor appeals in the same manner. This will enable the provider to know if it has actually corrected the issue and can expect to avoid the same persistent denials in future billing.

It is also important to realize that tracking denials and monitoring appeals is an ongoing process. For providers with high or otherwise unacceptable denial rates, the process of monitoring and tracking may begin as a quality-improvement initiative. When the necessary improvement has been achieved, however, the initiative cannot be abandoned. Rather, it must be converted into an ongoing quality-assurance program that keeps denials low and promotes billing accuracy.

Rely on Relationships with Payers and Payer Resources

Although the amount of information sent by payers to providers can be overwhelming, providers must carefully review and evaluate the billing and coding actions required from every piece of correspondence sent by providers. This might seem to be one of those "well, of course" recommendations, but in my experience, many providers struggle under the weight of information overload and simply fail to heed important billing notices. This is a leading contributor to claims denials.

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Many payers have taken the helpful step of making their billing guidelines available online and developing effective search engines to make it easier for payers to find the necessary information. Along those lines, payers have an obligation to provide clear billing guidelines. When there are changes to those guidelines, the notifications should be clearly marked—in other words, the provider should not have to hunt for guidelines among the dross of less-important information. Billing guidelines should list every coding requirement for every type of claim; list clearly what the payer considers to be all the necessary elements of a clean claim that can be readily processed, and how the payer pays in all applicable claims scenarios. Am I describing the payer's typical supporting documentation? If not, read on for how to resolve such issues.

Next to tracking denials and appeals, establishing person-to-person relationships with payers is the most important step providers can take to improve their billing accuracy. In my experience, compliance officers and auditors benefit greatly from developing relationships with representatives of the payer's provider relations and auditing teams. That way, when there are puzzling or persistent issues that the provider simply cannot seem to figure out, the provider can call the payer and ask for help in solving the problem.

Of course, there will be times when providers find that payers are not providing the information or cooperation needed to bill accurately. In that case, providers should not be reluctant to make specific requests. As with most working relationships, the 'squeaky wheel' does in fact get attention from payers. Providers should not hesitate to request additional clarification when processes are murky or the remittance notices explaining why claims are denied are unclear. Providers need to ask what they are doing wrong when a type of denial cannot be cleared up; be persistent in getting an explanation that solves the issue.

Providers should avail themselves of any training resources the payer offers. Many payers offer training at the provider's office. Payers also hold training at their offices and offer online webinars and telephone conferences. Along the same lines, providers should take advantage of any educational programs, which are often offered by state Medicaid programs and other big payers. National and regional billing conferences are another valuable resource. Although there are costs associated with lost productivity, providers usually more than recoup the investment by avoiding denials.

Additional Observations and Recommendations

Closing the Loop: Making Effective Appeals. As with monitoring denials, exhorting providers to adequately document the basis for appealing denials might seem to be an obvious recommendation. I frequently see appeals letters that state that a claim was reimbursed incorrectly, yet the provider neither indicates why the payment was incorrect nor provides documentation. Providers need to know that when a claim is denied, it probably because an edit was triggered in the payer's claims-auditing system. It may be a mistake on the payer's part, but it's more likely that the claim as coded did not match the requirements in the payer's system. Providers must appeal suspected payer mistakes or rebill using different coding by using the correct documentation, such as copies of the medical record or copies of the bulletins and transmittals received from payers. Effective appeals pinpoint a specific issue and succinctly identify the relevant issue.

On the Risk of Criminal Investigation. Providers are well aware of the federal

government's growing efforts under the False Claims Act (FCA) to investigate healthcare fraud, prosecute offenders and recoup funds for Medicare and Medicaid. Given that the vast majority of providers are not engaged in fraud, government action has limited relevance to providers reading this article. There are, however, several points of interest to be made. First and foremost, as a rule, payers have no interest in seeking out or alleging fraud on the part of their providers. Providers should know, however, that payers will pursue suspicions of fraud when there are strong indications of it. Moreover, although payers would prefer to work with providers to help them identify and correct repeated errors, CMS may not be so collaborative. Ignoring the remittance advice that explains why a claim is being denied can be construed as a willful disregard for the truth and lead to allegations of fraudulent billing even though the provider did not intend to commit fraud.

Providers should also be aware of a relatively new development: state- and local-level implementations of the False Claims Act. Traditionally, the FCA has been a federal statute under which investigators have focused primarily on suspected fraud against federal programs. At the prompting of the federal government, many states and localities have enacted their own FCAs, which has opened another avenue for investigation and scrutiny of providers and their billing practices. A result of newly coordinated investigations is increasing scrutiny on commercial payers and how they reimburse their providers.

Prepare Early for Annual Coding Changes. As providers know, there are no more grace periods when annual coding changes take effect. Deleted codes, additional codes and changes to codes immediately affect billing accuracy and impact revenues. Providers need to begin preparing for coding changes well in advance of their effective dates. As the volume of changes continues its seemingly inexorable rise (there will be 519 CPT code changes effective January 1, 2009), taking the necessary steps to prepare in advance is increasingly important.

Conclusion

In the final analysis, a key measure (perhaps the key measure) of a billing and compliance staff's effectiveness is its success in billing accurately for all of the revenue a provider is owed. Although the provider-payer relationship can at times be a frustrating one, it is my experience that payers truly want to establish collaborative working relationships with their providers. Achieving that kind of relationship is, however, a two-way street. Payers have an obligation to pay accurately according to the terms of their contracts, and they have a responsibility to provide useful, accessible information that supports provider billing. Providers, for their part, must keep up with payer bulletins, heed remittance notices, eliminate persistent denials and submit accurate claims.

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Although it is not a formal obligation, providers can help themselves by proactively taking steps to improve their relationships with payers. There will, of course, be times when a provider cannot get the support or the answers it needs from a payer. In such cases, the provider should take steps to evaluate whether the relationship with the payer is fruitful and worth continuing. If, after trying to resolve billing issues, the provider and payer cannot reach accord and denials continue to pile up, the provider may have to consider terminating the contract. After all, providers should not have to settle for writing off claims that are denied. By taking directed measures, however, providers can reduce their denials rate and boost their revenue by billing accurately and effectively claiming all the revenue owed. **NP**

Andria Jacobs, RN, MS, CEN, CPHQ, CCP, is chief operating officer of PCG Software. She can be reached at ajacobs@pcgsoftware.com or 877-789-1291 ext. 203.