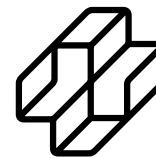


# Revenue Cycle Strategist



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## Denials Management and Appeals: Rooting Out the Cause

By Joyce Mosier

*Denials are a barrier to payment, making their cumulative impact significant to the bottom line.*

Denials occur regardless of the payer source. Their timing may be immediate or delayed. They may occur at the time certification is sought or at audit. Regardless of when they occur, each requires attention. Denials may vary by geographic region or contract basis, but they have causes in common. It is important to know the types of denials, sources from which they originate, and the timing in which they occur.

Vanderbilt University Medical Center (VUMC) in Nashville, Tenn., has implemented processes for denials management before and after billing. Denials and appeals are addressed in a collaborative environment for each broad denial category. These processes have facilitated sustained successful performance by reducing write-offs from 3.5 percent of total charges in 1995 to as low as 0.01 percent and less than 0.4 percent every year through FY07.

Providers should identify areas of vulnerability for denials and communicate throughout the revenue cycle to reduce losses. Closed loop communication as it applies to denial management is a process of front to back and back to front exchange of pertinent information. It is fluid and dynamic. It relays specifics of performance outcomes related to initiation of revenue cycle aspects through contract performance. Closed loop communication is vital to physicians and hospitals to avoid incorrect assumptions that could result in sustained financial loss. It is the foundation to process improvement.

### Process Improvement Approach

Whatever the percentage of denials or whether they are technical (hospital-generated charges) or professional (physician-generated charges) denials, providers should have an effective denials management and appeals program in place. Providers should take a process improvement approach, which

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### COMING IN JULY

**The RACs are coming! The RACs are coming! Learn more in the next issue of Revenue Cycle Strategist.**

### HFMA Resources

HFMA's payment reform retreat looked at principles of an ideal payment system. Read the report *Building a New Payment System* online at [www.hfma.org/library/reimbursement/paymentreform/400599.htm](http://www.hfma.org/library/reimbursement/paymentreform/400599.htm) leadership.

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requires a root-cause analysis. The coded reason on a remittance advice alone does not help providers identify the cause of a denial. A root-cause analysis can help providers identify and correct the initiating factor.

For example, a trend in denials for no authorization appeared to be a registration problem at VUMC. Feedback from staff led management to believe that patients were presenting only partial insurance information, resulting in a problem with coordination of benefits. Many claims were denied because the primary insurance information was missing. Analysis showed that the root cause was verification of insurance, rather than a partial insurance capture. VUMC needed to revise its policy. The identified problem required a different process improvement than primary re-education of staff on data entry of insurance. All denials require a similar level of scrutiny for category, type, and recommended resolution.

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*Revenue Cycle Strategist* is published monthly by the Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154

Presorted standard postage paid in Chicago, IL 60607.  
©2008 Healthcare Financial Management Association.

Volume 5, Number 6

Subscriptions are \$107 for HFMA members and \$165 for other individuals and organizations. Subscribe online at [www.hfma.org/rcs](http://www.hfma.org/rcs) or call 1-800-252-HFMA, ext 2. To order reprints, call 1-800-252-HFMA, ext. 387.

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*Revenue Cycle Strategist* is indexed with Hospital and Health Administration Index and the HealthSTAR database.

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ISSN: 1549-0858

## Denial Categories and Types

Denial groups and types of denials within the broad categories are complex. Groupings include preadmission, concurrent, post-billing, and audit.

### *Preadmission denials.* Preadmission

denials occur when a provider attempts to obtain certification before admission. These denials include denied as investigational, denied as noncovered, and denied as not medically necessary:

- > Denied as investigational may include new equipment or a new approach. For example, when robotic surgery made its debut, some payers denied claims for this procedure as investigational. As the robotic surgical technique is expanded to other surgery types, it continues to be challenged.
- > Another example relates to research in which a device is implanted and is noncovered. Standard medical care may be covered, but the research component may not, resulting in a complexity of payment. Denied as noncovered may be due to research, but also may stem from an insurance rider eliminating coverage related to specific circumstance, pre-existing clause eliminating something previously diagnosed, or a noncovered benefit such as cosmetic surgery.
- > Denied as not medically necessary can include cases that need specific documentation to meet medical standards of care to qualify for surgery or to avoid denials for a delay in service. This denial type can be a source of avoidable days and affect patient throughput as well as case-specific dollar loss.

### *Concurrent denials.* Concurrent denials occur

while a patient is in house or at discharge. A payer responds with an initial denial to clinical detail given by a nurse to the payer's nurse or medical director. These denials can include types listed under preadmission. A common concurrent denial is a level of care issue such as intensive care setting denied as not medically necessary or acute

level of care denied. For example, a request from a payer to accept skilled nursing level payment in the acute setting is a denial for acute care. An insurance company representative may present this information not as a denial but as a lower level of care payment.

If a negotiated acute care rate exists in contracts, why would an impromptu renegotiation be appropriate? Care delivered in an acute care setting is either medically necessary based on medical standard of care or it is not. If a safe discharge is not possible or a skilled nursing facility is not available, the acute level of care is reasonable. Therefore, addressing this issue as a denial is appropriate. Contracting personnel and provider relations personnel should work together to resolve the matter.

*Postbilling denials.* Post-billing denials occur when the remittance advice returns with a denial code. For the purpose of this article, denial codes are designated as not certified (no authorization), not medically necessary, or denied inpatient as appropriate for outpatient status or for 23-hour observation status. Many root causes exist.

A few scenarios are listed here:

- > A certification (authorization) exists for part of the length of stay, but a few days are denied. The denied days, even though part of a longer stay, are designated by remittance advice denial code as not authorized. On examination, the underlying cause may be a lack of medical necessity or a mistake by the payer. Each reason requires a different intervention.
- > A patient presenting with medical symptoms and for whom an authorization for care is obtained timely by the acute care hospital is denied for no authorization due to a behavioral health principal diagnosis. A denial code for no authorization is listed but the denial code is misleading based on the root cause. A medical insurer does not honor the authorization due to the psychiatric diagnosis. A behavioral health payer

denies because of location of service and no authorization. If this postbilling scenario is a trend, it can be addressed in contracts between providers and payers.

It is important to understand the underlying reason of the denial because a no certification (authorization) designation may also be denied by the secondary payer or not be billable to the patient. The category masked as no certification (authorization) may actually be a noncovered condition or a mistake on the payer's part. It can also

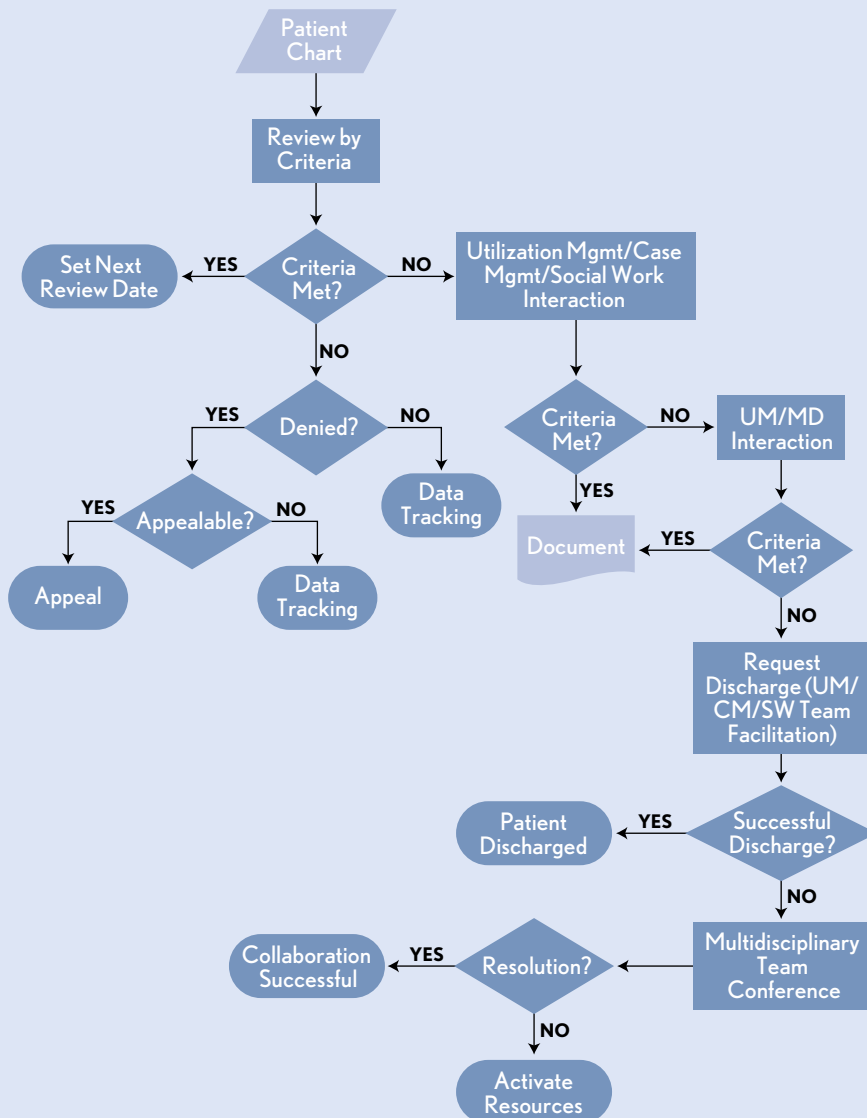
be related to inpatient versus outpatient billing status. Issues related to inpatient versus outpatient status are complex and warrant a separate discussion.

**Audit denials.** Audit denials occur when cases are audited by government or commercial payers. It is helpful to communicate audit results or questions to staff who obtained the original authorizations. Original sources are an often untapped valuable resource in problem solving. Those staff members usually have pertinent information related

to the initiation or continuation of authorizations. This is a critical asset as Centers for Medicare and Medicaid Services (CMS) recovery audit contractors and Medicaid integrity programs gear up for expanded audits that will require aggressive appeals. Information about medical necessity screening based on industry standard criteria is a foundation to any appeal. The more skilled staff members are using and applying industry standard criteria from preadmission through the entire length of stay, the more successful appeals will be. This also applies to appeals of audited cases.

## Denial Management Process Vanderbilt University Medical Center

### Concurrent Resolution Process



### Impact of Denials

The impact of any denial can be a partial payment or complete denial of payment. If payment is per diem, a partial payment or a total denial is possible. If payment is on a per-case basis such as a diagnosis-related group payment, a denial becomes an all-or-none proposition. The need to communicate with staff involved at any stage of the revenue cycle is imperative to an effective denial management process.

Denials related to observation status versus inpatient status are particularly challenging due to differences among commercial payer contracts with providers and CMS regulations. It is helpful to remember that outpatient status for surgical patients was originally deemed appropriate for low-risk, otherwise healthy patients. Commercial payers have evolved outpatient status to include overnight outpatient stays for higher risk patients and have a tendency to determine status based on length of stay alone. The type of denial is listed here because it can have considerable impact on a hospital's or physician's financial outcome. Resolution of root cause should be decided with help from compliance professionals and the provider's contracting staff.

### Closed Loop Communication

A strong denials management and appeals program involves closed loop communication among all parties touching aspects of

the revenue cycle. A root-cause analysis can be performed for all denial categories to avoid erroneous assumptions about causative factors of individual denials. Categorize trends, apply interventions to processes, and follow those processes to assess improvement. Effective front-end actions include capturing insurance completely, verifying insurance to the benefit level and not just eligibility, verify certifications if obtained by providers other than the facility, and obtain certification if it is not in place. The front-line process staff should communicate specific, concurrent problems to the billing entity, such as exact dates of service denied if a partial denial is received.

The flowcharts illustrating VUMC's denial management concurrent resolution process (see page 3) and post-billing denial process (see [www.hfma.org/rcs](http://www.hfma.org/rcs)) are examples of closed-loop communication.

If an audit occurs, a team composed of revenue cycle representatives from each phase of the process should address questions that arise during the audit and discussion of audit results. Audit questions and audit results assist in identifying potential areas for process improvement in documentation, processes, or clarifying expectations of payers and providers. Feedback of results to all points in the cycle is important to improve outcomes. Revenue cycle personnel can work collaboratively to appeal audit results disputed by the acute care or physician provider, often resulting in a positive outcome. ☞

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View the VUMC postbilling denial process flowchart at [www.hfma.org/rcs](http://www.hfma.org/rcs).