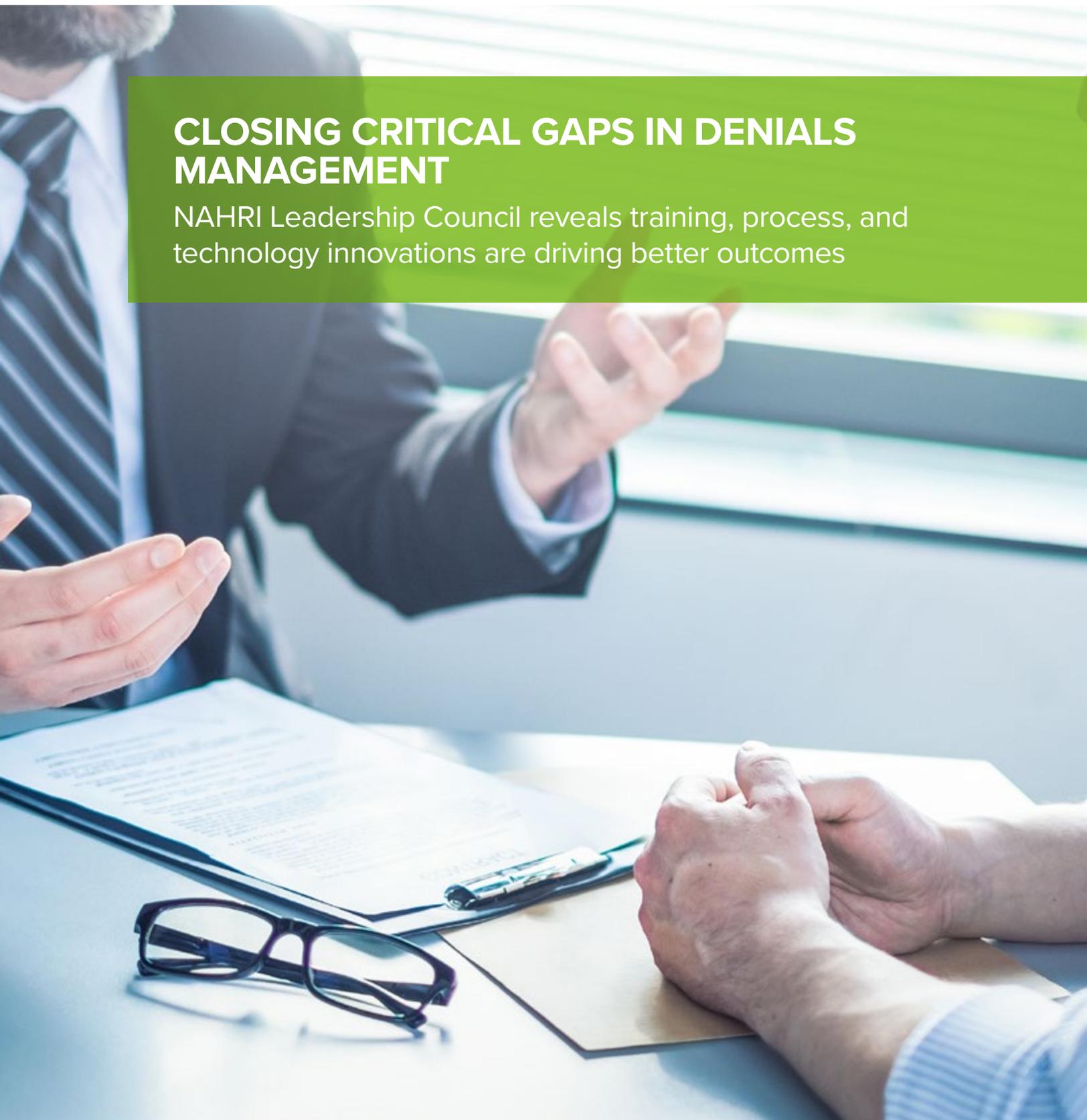


CLOSING CRITICAL GAPS IN DENIALS MANAGEMENT

NAHRI Leadership Council reveals training, process, and technology innovations are driving better outcomes



ROUNDTABLE PANELISTS



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Closing Critical Gaps in Denials Management

NAHRI Leadership Council reveals training, process, and technology innovations are driving better outcomes

Denials management continues to be a significant challenge

for healthcare organizations in 2021, made worse by the pandemic. Now revenue integrity, coding, and HIM leaders are doubling down to improve training and workflow processes, as well as turning to advanced technologies to reduce coding and documentation errors, speed up review and audit processes, and ultimately drive more clean claims out the door to minimize denials.

In the 2021 NAHRI Council Survey on denials management, 100 leaders, including those from revenue integrity, revenue cycle, compliance, and HIM, shared key insights on denial trends. Respondents revealed the coding and documentation issues with which they struggle most, the main reasons for denials, along with audit patterns and best practices for managing errors and denials.

Approximately half (51%) of respondents kicked off the survey by identifying sepsis as the primary reason behind coding and documentation denials. Respondents say the top processes for resolving coding and documentation errors prior to claim submission include using claim scrubber technology and coding edits at the point of coding. Interestingly, while there is much emphasis on coding and documentation, most respondents say these areas represent less than 10% of denied claims, which points to a need for a broader approach to denials management.

A roundtable panel of revenue integrity and coding leaders recently convened to discuss the survey results. They also shared their top coding and documentation challenges, best practices, and the critical role technology plays in streamlining workflows, enhancing auditing practices, and reducing overall denials. Here is a summary of that discussion.

Top reasons for denials

What comprises the bulk of denials? Roundtable panelists agree that pre-authorizations are a top denial area.

“One of our largest denials right now is the pre-authorization area,” says **Karna Stroschein**, director of coding at Prairie Lakes Healthcare System in Watertown, South Dakota. This typically includes pre-authorizations for procedures and costly chemotherapy drugs. “We bill out thousands of dollars at any given time for cancer drugs,” she adds. A key oversight with Prairie Lakes’ Medicare Administrative Contractor (MAC) during the pre-authorization

process has led to repeated denials. “We didn’t realize that our MAC will provide a number whether it’s authorized or not. Our claims were denied because the numbers were actually non-affirmation numbers,” she says.

Authorizations are also a concern at Monument Health in Rapid City, South Dakota. “Right now, our No. 1 denial is denial code 197 for authorization,” says **Paula Twiss, MBA, CRCS-P, CRCS-I**, supervisor of revenue integrity. “Some payers deny labs, which weren’t typically an item that we would pre-certify. Now we are tracking and documenting CPT® (codes) and procedures that are being denied for authorization so that we can remedy the situation and look at payer policies,” she says.

Coding and documentation denials

Surprisingly, 84% of survey respondents say coding and documentation denials comprise less than 10% of denied claims, with 40% of respondents indicating they contribute to 1%–3% of denials. Even so, these denials are a top concern given the time and resources they take to resolve.

“We are in the 7%–9% bucket,” says **Jackie Woolnough**, director of revenue integrity at MetroHealth System in Cleveland. “Our No. 1 issue for rejections is registration errors. Our biggest opportunity is documenting the right insurance plan and information at the time of scheduling. Removing invalid payer plans within Epic should resolve this issue.”

The survey also indicates that sepsis is by far the leading cause of coding and documentation denials by diagnosis, followed by diabetes (13%), malnutrition (11%), respiratory failure (8%), congestive heart failure (8%), pneumonia (6%), and acute kidney injury (3%).

Roundtable panelists say they are experiencing the same types of denials. “Sepsis is our No. 1 denial from an inpatient perspective,” says **Katy Howard-Rife**, director of revenue cycle support at Indianapolis-based Eskenazi Health. “All of our coding denials go back to our coding team for review, and they work the denials.”

Similarly, Stroschein, with Prairie Lakes Healthcare System, says sepsis is a top denial area. “Physicians will say sepsis in one progress note and never refer back to it. We look at it as an issue to handle before coding,” she says. “We purchased a CDI product that helps with writing, and it has good documentation tips for the physician. We also use ACDIS information that helps us be more

proactive with physicians,” she adds.

“Diabetes is high on our list,” says Twiss at Monument Health. Diabetes claims typically get denied due to a missing or invalid National Provider Identifier code. She adds that the organization has improved accuracy by building modifications to ensure dietitians are added as providers to the claims.

“Sepsis is our No. 1 denial from an inpatient perspective.”

—Katy Howard-Rife, director of revenue cycle support, Eskenazi Health

MetroHealth System has also experienced an influx of diabetes denials driven by an issue with physicians’ documentation workflow, says Woolnough. “We had a trend in which Type 1 diabetes and Type 2 diabetes were being documented on the same patient. The physicians knew what kind of diabetes the patients had, but the documentation templates were adding in both.” Additionally, Woolnough says her department recognized

an opportunity to better capture Hierarchical Condition Category (HCC) codes for malnutrition by documenting and coding the patient’s BMI.

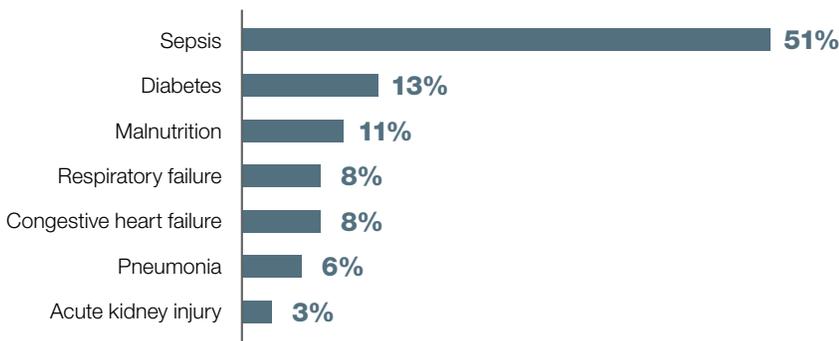
“We engaged with 3M on this over the last 18 months or so on our inpatient side and have had amazing progress with the documentation quality we were able to obtain,” she says. In fact, Woolnough says MetroHealth implemented an entire suite of inpatient software. “It has greatly improved our ability to identify opportunities in documentation not only for these areas but across the board, simplifying and speeding up the provider querying process.”

Audrey Howard, RHIA, senior inpatient consultant with 3M HIS Consulting Services, says the organization has a deep

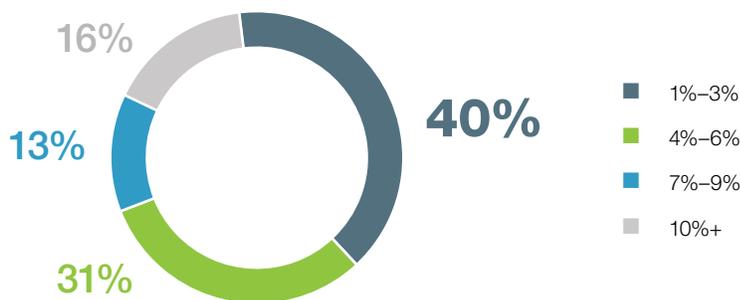
understanding of these types of coding issues and why mismatches between the code and diagnosis can lead to denials or reduce reimbursement. “We believe the best way to reduce these types of missed or incomplete codes is to add an edit, and when needed, a second-level review within the coding workflow at the point of coding.”

Howard also points out that coder fatigue is real and can be addressed with the right edits. “Coders see so many edits, causing them to bypass potential opportunities,” she says. “Our goal is to work with the organization to create edits that are specific to their unique coding challenges.”

What diagnosis is the primary reason behind your facility’s denials due to coding and documentation issues?



What percentage of your facility’s claims are denied due to coding or documentation errors?



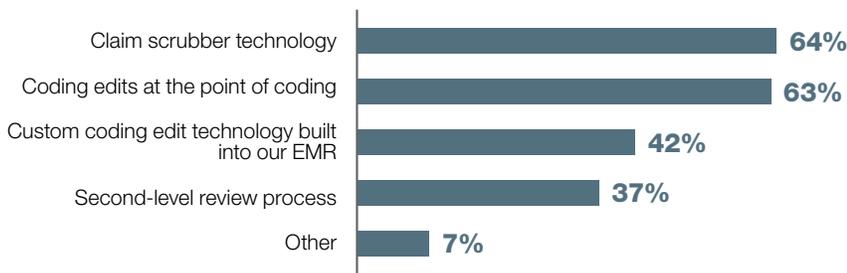
Resolving claims

Survey respondents indicate they deploy multiple strategies to correct coding mistakes before a claim makes it out the door. Claims coded incorrectly but caught before submission often are resolved through one or more of the following processes: claim scrubber technology (64%), coding edits at the point of coding (63%), custom coding edit technology built into the EMR (42%), or a second-level review process (37%). Generally, facilities have a review process (45%) or EMR process (32%) to catch incorrectly coded claims prior to submission.

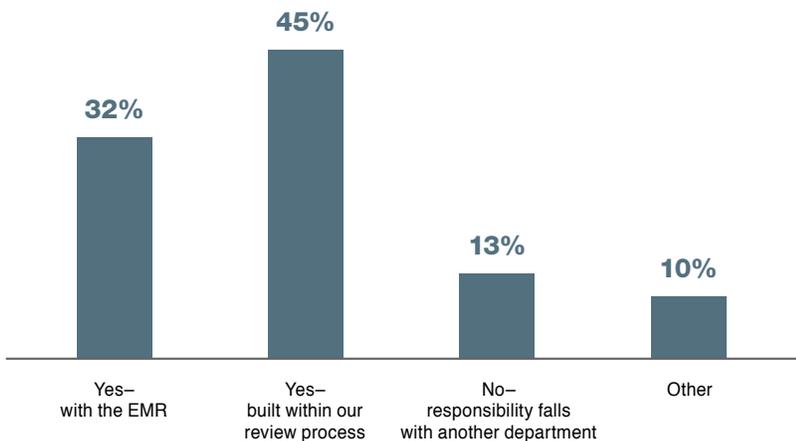
SOURCE: 2021 NAHRI Council Survey—Denials Management

Most members of the roundtable panel agree that their organizations catch coding mistakes through edits built into the EMR or through a technology program. Indeed, Woolnough with MetroHealth says coders have many edits available to resolve inpatient coding mistakes. “We also have upfront technology built-in for our coders that helps guide correct coding. We build in LCDs, NCDs, and MUEs so we can get a clean claim out the door without having to touch it,” she says. “There are also thousands of edits built into Epic for physicians who code their own service, and we also use a claim scrubber to catch coding issues.”

When a claim is coded incorrectly, which of the following best describes your facility’s process for resolving this prior to claim submission? (All that apply)



Was there a point in the process before the claim was submitted that the coding error could have been resolved?



SOURCE: 2021 NAHRI Council Survey—Denials Management

Woolnough adds that the department regularly finds coding opportunities to minimize rejections. “We then build edits within Epic to try to manage them there.” She notes that most recently, payers were rejecting diagnosis codes for vitamin D tests. “Now we review the test codes and adjust them before we send the claim out the door.”

Karla Gibbs, COC-H, principal analyst of revenue integrity at UCLA Health System in Los Angeles, says the department of revenue integrity has built coding edits into its work queue. “We are tasked to add the CDM, so we do not bring it back to our physicians. We have the opportunity and the security to review the documentation,” she adds.

“We’re small enough where if we find an edit on the 3M side or within the billing edit, we take it one step further and send it back to the department and make them responsible for the correction,” says Stroschein with Prairie Lakes Healthcare System. “We feel education is critical to changing processes, so we help them understand what they missed, why they’re getting an edit for a device, or why they use chemo administration on a non-chemo drug or vice versa. We also build in those edits, which reduces the coding problem,” she says.

Moreover, Stroschein says coding edits are generally caught and resolved through various work queues, a claim scrubber, or claim edits. “We are hyper-focused on minimum days and make sure we are automating processes and have many different sets of eyes on charges and diagnoses to get a higher clean claims submission rate,” she says.

“In many cases, we go back to the provider because it has to do with their documentation,” adds **Priscilla Frost, AGS, CPC**, coordinator of revenue and compliance auditor for North Caddo Medical Center in Vivian, Louisiana.

Twiss, with Monument Health, says claim edits get categorized by revenue cycle area. “For example, one set of edits might be for registration and would address errors such as a missing primary care provider. We also have a claim scrubber through our clearinghouse, and we are big on working sessions in which we troubleshoot claim edits.” Twiss says working sessions help identify patterns that lead to several types of solutions, including eliminating an edit, changing workflows, and providing education.

“Over the years, I’ve watched coders and managers apply various approaches to catching denials,” says Howard with 3M HIS Consulting Services. “I believe the best process is to identify the potential denial during the coding workflow, take the corrective action, and send it through the process,” she adds. “Ultimately, this will reduce the additional time and rework. Further, customized edit prompts will assist the coder in catching these potential denials.”

Managing denials

Survey respondents turn to a variety of metrics to manage coding and documentation denials, including actual data within a specified time frame (40%), trends to determine historic and current perspective (33%), specific issues or categories (15%), and all of the above (12%).

“We use all of the above, including current actual data, which we apply back to trends to see if it’s something new or if we are accustomed to it,” says Woolnough with MetroHealth. “We also target specific issues,” she adds. “When we’re looking at actual data, we take 100% of the rejections that come in weekly and use an internal mapping system to link remit and remark codes to coding, authorization, billing, and other areas. They are then mapped to an appropriate area and reviewed on a 100% basis,” she says.

“We have done much work on our denials since going live with Epic about three years ago. We trend over time, look at the enterprise level, and drill down by location, department, and CPT.”

—Paula Twiss, MBA, CRCS-P, CRCS-I, supervisor, revenue integrity, Monument Health

“We take the data based on the reason code, and then we look at the actual RA and the line item denial,” says Gibbs with UCLA Health. “We have certain workgroups that, at least on the outpatient side, drill down to try to see whether it’s payer specific, a registration issue, or due to a myriad of other reasons,” she says.

“We have done much work on our denials since going live with Epic about three years ago,” adds Twiss with Monument Health. “We trend over time, look at the enterprise level, and drill down by location, department, and CPT,” she says.

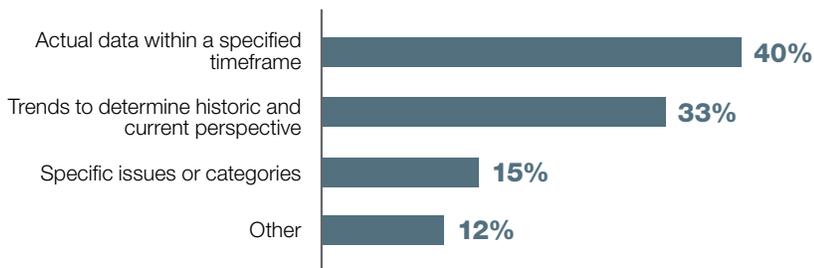
“In terms of metrics, we’re looking at volumes of denials and dollars in denials,” says Howard-Rife with Eskenazi Health. She notes that a hospital denials committee meets biweekly to review denials by reason codes. “The top five denials are constantly being looked at and then added to as we address root cause issues.” She adds that each department looks at its denials and places items back in its work queues. “We also look at denials from a coding and documentation perspective to ensure that 100% of the accounts are looked at before they were billed out, especially in the outpatient setting.”

At the same time, the majority (73%) of survey respondents are auditing denied claims for root cause every month. Twiss says Monument Health also performs monthly root cause audits on

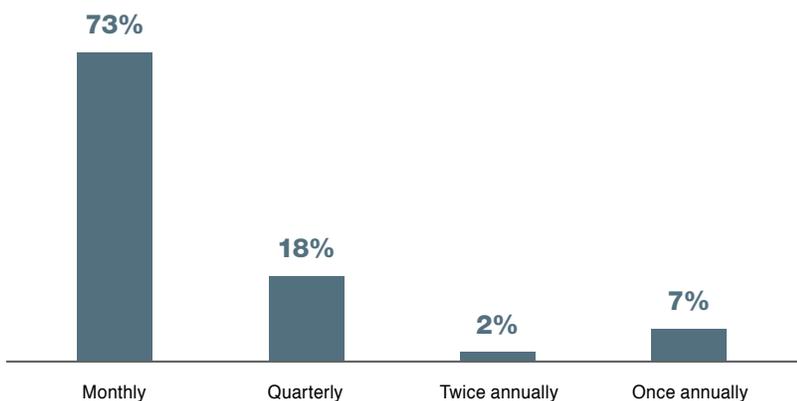
denials. “We’re trying to capture the prior month’s denials and identify root cause based on things that have been completed within the denial record in Epic,” she says. “One thing we’ve determined is that we need to hold claims to prevent denials in specific areas. One of the areas is our newborns waiting for insurance to be added to their account. We now have a process in place to hold the claim for a period of time and then follow up with the mother.”

Adds Frost with North Caddo Medical Center: “We’re doing a monthly audit, and one of the things that we discovered in doing this is that because our clinics are on a different EMR, their chargemaster has been causing many problems and not being updated. Now we have in place a special group that watches them as well.”

What type of metrics are used to help you manage your coding and documentation denials?



How often does your facility audit denied claims for root cause?



More work ahead

Finally, 68% of survey respondents say they overturn less than half of all denials, while 25% overturn 51%–75% of denied claims. Gibbs says the tools for success depend on a number of factors. UCLA has learned that “you need to work as a team, provide the right tools up front to the people getting the authorizations, and educate physicians on what constitutes medical necessity.”

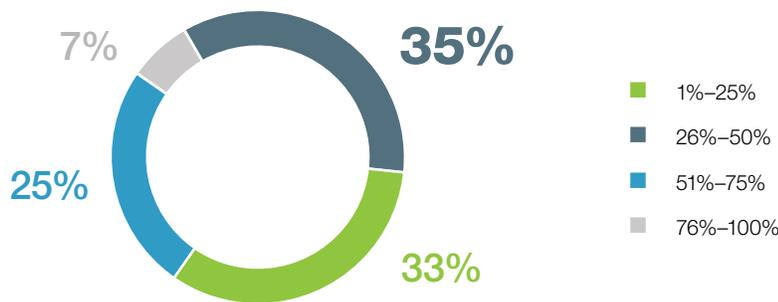
SOURCE: 2021 NAHRI Council Survey—Denials Management

Howard, with 3M HIS Consulting Services, says while audits are a great way to ensure accuracy, they should not be the only avenue of doing so. “Reviewing the metrics that identify the number of times an edit was triggered should show a downward trend for the audit errors,” she says. “If you catch the errors specific to the

organization at the point of coding, you reduce the potential audits that find issues.”

Although coding and documentation denials make up a small percentage of overall denials, the HIM department has immediate control over them. The department can use technology to identify potential coding errors (ideally at the point of coding), allowing them to easily make changes or send high-risk codes for second-level review within the coding workflow. This will ultimately improve coding accuracy, save time spent on rework, and reduce the 10% of denials related to coding or documentation errors. ■

What percentage of your facility’s denied claims are overturned?



SOURCE: 2021 NAHRI Council Survey—Denials Management

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