Denials Management 2.0: Putting Some Management into Denials Management

BY JENNIFER KROKEN, MBA

There have probably been a million articles written about denials management. This is the millionth and one.

Denials management has frequently been sold as a billing company benefit; published, presented, and discussed ad nauseam for years now. As a practice manager do you 1) have spare time to donate to denials analysis and 2) know what to look for even if you did have the time?

Unfortunately, it is important to make time or delegate the task of a denials review because it not only remains a relevant topic, but the game is changing regarding how denials work and why they are more important than ever to prioritize on an ever-growing "to-do" list.

This article is not an effort to define what denials are and are not (since you can reference the other million articles that do so) but rather, to provide you with just a few things to look for…and how to get your claims paid.

Briefly: What Denials Management Is…and Isn't

To provide a very brief overview, denials management is the analysis of denial codes (usually provided at the time of payment posting) for the purpose of identifying problems and trends—and taking action on the cause of the denials when possible. What it is NOT is simply posting denials, providing a report of said denials, and sending out a series of follow-up letters to insurance companies to acknowledge the denials.

If your practice utilizes the services of a billing company, they will all undoubtedly tell you they have a denials management program, but too often, it means only that they can provide a denials report and send out letters. While reporting and letters are a crucial component to managing denials, they are not the answer…and they are certainly not a denials management program.

Make sure you feel comfortable that your billing service or staff can really think through the numbers and forewarn you of trends, as well as develop a solution to correct them. With that said, let's discuss just a few very specific denials that when worked, can put money in your practice's pocket.

Missing Information

Missing information denials can run the gamut from simply needing to provide a primary payor EOB to the secondary insurance to submitting medical records to justify a patient's vertebroplasty procedure. What is important to note is that 9.9 times out of 10, the records being requested are needed from the practice…not the patient. Read: Do NOT ignore these denials or they will just sit there, along with your money.

Here's one tricky denial reason provided by Aetna. In this example, Aetna is the secondary payor but we'll say the hospital sent it over as the primary payor. The denial you will see says something to the effect of (paraphrasing) "we have requested more information from the member…." Don't be fooled—this means they are not the primary insurance and if you wait for the patient to respond, you'll never get paid…or miss filing deadlines. If you see this denial, log on to the hospital system and find out who the primary insurance may be. (The information is probably there, but may have been added after you received your download.) A more complicated denial to work is a "missing records" request from the Blue Cross payors. When BCBS requests records, they are often fertility treatment records, history and physicals, treatment notes—essentially everything but the radiology report. Until recently, radiology groups used to get by with sending off the radiology report and telling BCBS to request the records they need from the other provider then the claim would be paid. However, this approach no longer appears to work.

Unless you want the claim to sit on your A/R for months or years (if you don't believe me, test one) my professional opinion is that BCBS has now made it the radiology groups' responsibility to ensure the non-radiology records are received. (This trend also appears in the more recent Medicare CERT audits—the government could care less what you have access to—they want you to send it all whether you own it or not!) Hopefully you have a cooperative hospital or referring doctor, but in my experience, the records are actually quite easy to get.

I certainly don't agree with BCBS placing the responsibility to get the records they request squarely on the shoulders of the radiology groups, but it's up to us to play the game—no matter how unfair it may be. Unlike many of my peers, I also wouldn't write the procedure off because it's too much time and trouble to follow up and track down the records. We're saving enough time with advanced automation to allow for the inefficient stuff.

Duplicates

I wrote an article a few months ago about duplicate denials (**The Not-So-Common Warning Signs of a Troubled Billing Practice: Part I**) which outlined why duplicate denials usually happen, what they mean, and how to stop them. One source of duplicates I did not mention (because it is usually not as prevalent as the others) is receiving a duplicate denial because another provider has been paid for your professional component portion of the radiology service.

Unless you or your billing company are in constant review of your denials, this tricky denial may go unnoticed unless you have a representative who speaks up once they identify a trend.

This type of denial can usually be narrowed down to either a site of service or a specific physician. Unfortunately it is not terribly uncommon for ER physicians to bill for the PC before your practice gets the chance to. A few here or there (here or there meaning every year or two) can be considered acceptable but a few a week—not so much. Tread carefully here since the ER physicians are technically on your team, but don't be afraid to let it be known that the radiologists are to bill for the PC—even though the ER doctor may "read" it first—their read is really a preliminary read, at best, which is not something that can be billed for. While they seem to test the water on occasion, they usually back down when the practice (and the scope of the radiology contract) is called to their attention.

However, this denial has also helped us identify problem contracts. "Paid to another provider" or "duplicate" (when you've only billed one study one time) can be a trigger to drill down to a particular site of service or referring doctor to make sure everyone is on the same page for who bills what. Once this denial trend becomes problematic, it would be wise to alert physician leadership since there will undoubtedly be political savvy required when addressing this issue.

It should be said that if your A/R representatives do not feel comfortable, willing, or safe in bringing up problems (trends) to your billing manager, you could be hung out to dry unless you are actively reviewing your denials report. If you do not think you can rely on your reps or payment posters to identify a trend, then make sure to review your denials report at least every six months because what you don't want is to find that a particular type of denial has been an issue for more than a year. No one wants to be in the position of trying to explain how to resolve an ongoing problem to the board and why it went undetected for so long—because that buck stops at the managerial level.

Other Insurance

The other insurance denial used to be a little easier to work before the emergence of managed Medicare and Medicaid plans. While frustrating, other insurance denials indicate the patient has just that—insurance other than the one you billed. Patient insurance information, usually gleaned from the hospital download, is notoriously poor. However, with managed government plans, a patient in the ER may state "I have Medicare" which is true—however, it may not be the Medicare we've grown to love—it may be an Aetna plan, a United Healthcare plan, or some other offshoot no one has heard of.

The problem with this denial is that there are often timely filing considerations built in. So while a "passive" collections policy may be to flip the charge to the patient in hopes they call you with their information, you may miss filing deadlines in the meantime, and since these are government plans, you cannot bill the patient. Result? You just adjusted off a perfectly collectible charge. Even worse for the practice, insurance-savvy

patients may alert their insurance that you are attempting to make the bill their responsibility when they know well that the provider is not allowed to collect from the patient, which could draw unwanted government attention to your practice. Even worse for patients, an unknowing patient, may pay a bill they are not responsible for.

Conclusion

It has not gone unnoticed in our industry that we are all working a little—or a lot—harder to collect what either seems to be or actually IS less money. More and more patients are moving to catastrophic plans or high deductible policies simply to maintain insurance coverage. What that means for us in the billing game is that the "old" collections philosophy of billing the patient or ignoring the duplicate denial as some fluke simply won't cut it anymore.

As reimbursement continues to ratchet down, radiologists may be quicker to outsource the billing function or, if they are already with a good and reputable billing company, may be enticed by "too good to be true" lower fees offered by a lesser billing company. To provide the best service possible to your radiologists and keep you and your staff in business, a periodic to frequent review of your denials may be in order. It is also important to remember denials are also fluid and ever-changing. Yes, we may have the same categories but the "how to" can change, so again, there needs to be regular review and validation of what's going on.

A denials report is simply that—a report. It is up the leaders in the organization to ensure the report gets translated into actionable items and quite possibly more money.

JENNIFER KROKEN, MBA
is currently a consultant with Healthcare Resource Providers based in Albuquerque, N.M. She has been a healthcare consultant for 10 years and also acts as operations manager for Radiology Consultants of North Dallas. She has presented at national conferences for the RBMA and is published in several industry publications. *Jennifer can be reached at 817.403.3355 or jkroken@radconsultants.com.*