White Paper

Mastering Denials Management Guide

Strategic Insights for Revenue Cycle Leaders

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Introduction

If past behavior is indeed the best indicator of future behavior, healthcare providers can expect to see commercial payers and Medicare Administrative Contractors (MACs) doubling down on denying, downcoding and underpaying legitimate claims for reimbursement. As providers and payers navigate changing policies across healthcare billing, they are also adjusting to higher volumes and shifting case mixes, higher costs on all fronts, an ongoing staffing shortage and disruptive technologies that break and shift traditional paradigms. To keep up, providers need a renewed focus on core revenue cycle processes like clinical documentation and coding, and to improve billing and follow-up workflows with a more sustainable, scalable and tech-supported process.

Clinical denial root causes

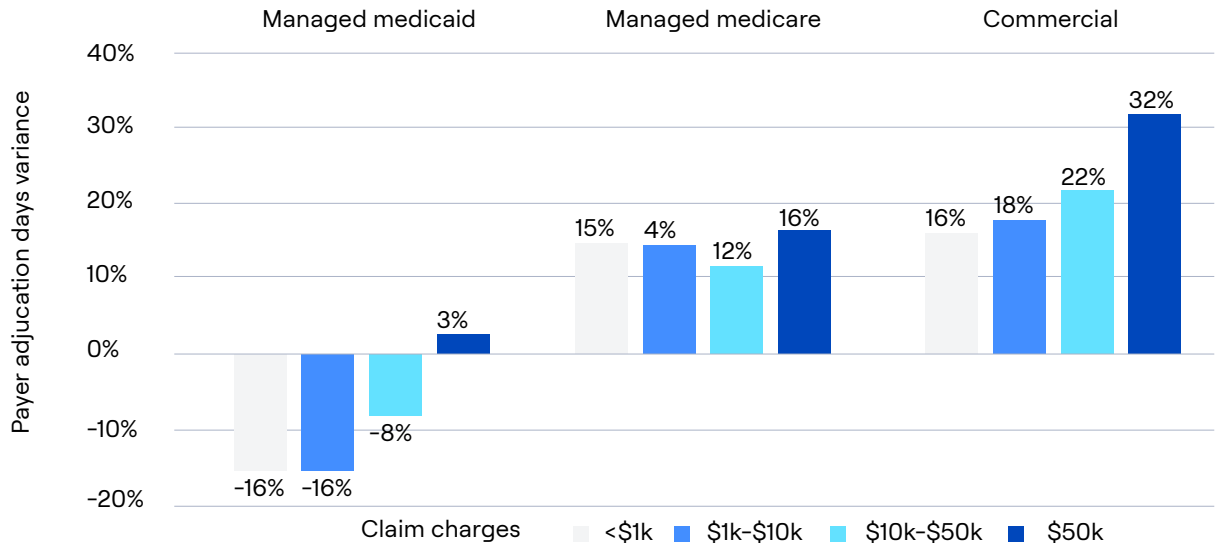
- Lack of medical necessity
- Re-admission
- DRG downcode
- Delay in service
- Non-emergent service
- Experimental/investigational
- Medically unlikely edits
- Lower level of care

Technical denial root causes

- Lack of authorization
- Lack of IP notification
- Out of network
- Not covered under clinical policy
- Lack of eligibility/benefits
- Coordination of benefits
- Untimely claim
- Untimely appeal
- Billing error

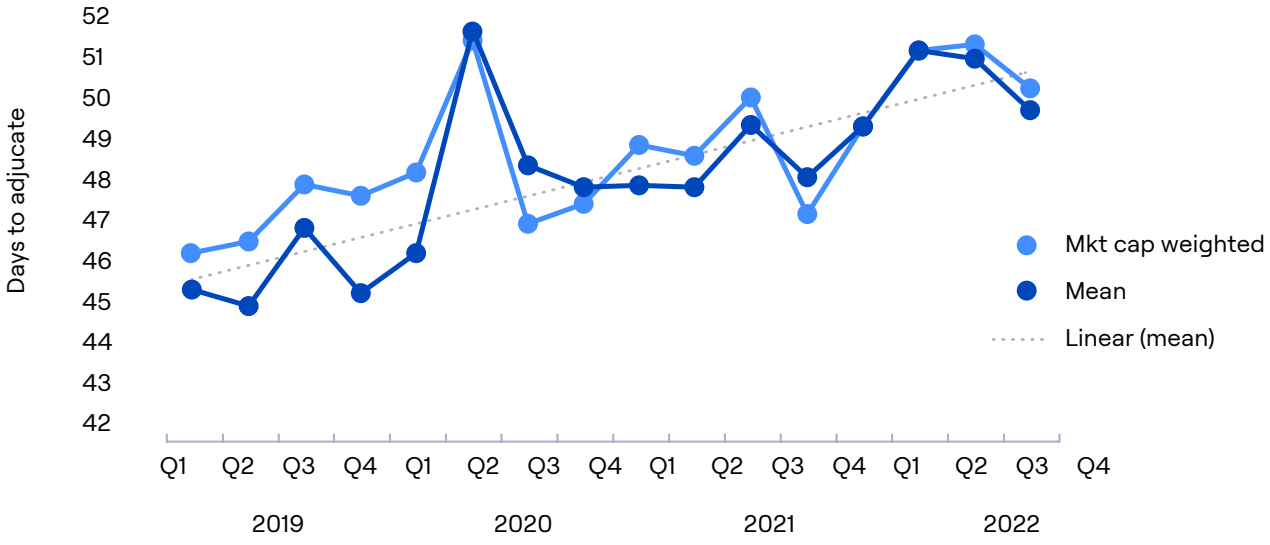
Because we work with over 90 of the top 100 hospitals and health systems in the country, we have unique visibility into millions of transactions representing more than $850 billion in net patient revenue (NPR). We analyzed that data to identify insights for developing quality improvement guidance across every stage of the revenue cycle. While developing the 2023 Revenue Intelligence Data + Insights Report, certain trends came into focus. Among the back-end processes most impacting revenue, denials and billing/follow-up stood out. The data shows that for high dollar claims greater than $50,000, commercial payers saw more than a 30% increase in days to adjudicate compared to 2019.

Negative payer behavior trends reflect delayed payments to providers



Increase in adjucation lag
across commercial and managed care payers since 2019

While COVID-19 did not necessarily cause a more rigorous denials landscape, it did catalyze payers' existing push in that direction that has continued post-pandemic. As claim volumes and complexities increase and labor shortages remain, hospitals should rethink their approach to denials management to recover lost revenue and establish more efficient post-pandemic practices.



Nearly 8% increase in days claims payable
across national commercial payers since 2019

The new denials landscape looks different

Increased medical necessity denials have spurred growing appeals

On top of the extended payer adjudication days addressed in billing and follow-up, the data shows a 40% increase in medical necessity denial rates across inpatient claims from 2019 to 2023. This material increase in denials means that providers must go through a lengthy appeal process that is not only time and resource intensive, but it also further delays a health system's speed to payment.

Considering medical necessity denials for inpatient claims are likely going to be high-dollar claims, this further supports our findings where payers are taking longer to adjudicate. As a result, RCM leaders feel the revenue pressure from delayed cash as well as the cost pressure from the increasing number of claims requiring manual intervention to appeal.

> Even a small percentage of all claims that requires an appeal is substantial because medical necessity denials are going to result in an extensive appeal process, which negatively impacts AR days and cost-to-collect."
>
> **Chris Hartemayer**
> Executive vice president of Patient Operations and Commercial Solutions at R1

Emergency Department level of care denials doubled in one year

Payers are increasingly using algorithmic systems to determine what gets paid versus denied or underpaid. In doing so they often eliminate certain factors from CMS guidance, such as facility resources and population statistics, resulting in more downcoding. These downcodes can fall through the cracks, especially if they involve lower balances. But over time, they can begin to negatively impact revenue.

Medicare Advantage (MA) inpatient denials are on the rise

CMS is requiring Medicare Advantage plans to follow the Two-Midnight Rule. As short-stay admissions become more common post-pandemic, hospitals see a growing number of inpatient denials as CMS cracks down on these one- to two-day stays.

Prior authorization waivers have tightened post-pandemic

During COVID-19, many payers temporarily eased rules around prior authorizations. Now, payers have turned those policies back on—and perhaps making up for lost time—with a more aggressive and scaled approach to denials, which as mentioned above is resulting in extended days for payers to remit such claims.

Artificial Intelligence tools are causing increased readmission denials

Payer sophistication with AI tools has also made readmission denials easier with payers automatically denying a claim if it happens within 30 days of another. This puts the onus on the provider to respond, oftentimes manually, to show the service was necessary.

Understanding downcoding: Why it matters and how to prevent it

While payers deny some claims outright, others are processed as partial denials that involve some level of downcoding and underpayment. Downcoding can be in two forms. In one, a provider bills a payer for a lower level of medical service than the care delivered. This could be attributed to errors in transcription, inadequate documentation, a misunderstanding of how to bill certain types of cases, or as a misguided tactic on the provider's part to avoid denials and audit scrutiny. In the other form, payers reimburse for a lower level of service than billed based on policy parameters without necessarily noting the downcode and underpayment.

Things have changed considerably in recent years, in part due to COVID and the disruptive, anomalous impact it had on revenue and costs for both payers and providers. Many healthcare revenue cycle leaders now perceive denials and downcoding as being caused as much by unfair payer practices as by internal documentation and coding quality issues.

The impact of downcoding

The American Hospital Association (AHA) considers the issue of payer downcoding and claims denial so serious that it issued a report pointedly titled, Addressing Commercial Health Plan Abuses to Ensure Fair Coverage for Patients and Providers. That AHA report found 89 percent of hospitals and health systems surveyed experienced an increase in claim denials over the past three years, with 51 percent calling the increase significant.

From a denials management perspective, there is discernable method behind insurance plans' efforts to incrementally downcode claims and downgrade diagnostic related groups (DRGs). Because DRGs determine reimbursement rates based on case severity and risk of mortality, with more severe and critical cases reimbursed at higher rates, payers tend to scrutinize those higher DRGs and look for opportunities to achieve lower-tier DRGs.

Third-party auditors working for the plans have incentives to downcode claims and come in looking specifically for opportunities that do not justify a higher reimbursement rate. Auditors will target those conditions that they know affect reimbursement, usually diagnosis codes that carry an MCC (major complications or comorbidities) or CC (complications or comorbidities) designation and look for clinical documentation deficiencies or inconsistencies that they can use to justify removal of the diagnosis. They are strategic in their reviews and most often target secondary diagnosis codes for removal. We see the same top 5-10 diagnosis codes consistently removed or revised throughout the country.

Recent downcoding developments

While payers leverage advanced analytics and big data to target high-value claims, healthcare providers struggle to push back against more and more partial and line-item denials and downcoded claims they must review, update, and appeal. For payers, the calculus is simple and strategic—it costs very little to downcode claims and DRGs, and much more for health systems and hospitals to appeal them. While steering clear of challenging medical necessity outright, the claim denial or downcoding often questions the clinical evidence supporting the initial DRG determination.

Much of that activity is based on a clinical validation review by the payers, so it's not just questioning the way a claim is coded and billed, it's questioning the provider's adherence to clinical guidelines and indicators that support a specific diagnosis or course of treatment.

The American Academy of Professional Coders (AAPC) also sees DRG downgrades resulting from clinical validation reviews as an issue and addresses it in a recent article stating, "Payers have been increasingly scrutinizing codes that raise the DRG and accompanying payment to determine whether the stated condition is supported by evidence. Claims that are high risk for scrutiny and denial often contain one diagnosis code that is a complication or comorbidity, serving to raise the DRG and reimbursement."

Countering payer downcoding practices

For health systems and hospitals, responding to payer downcoding is a strategic imperative for maintaining financial stability. But because it costs providers so much more to appeal than for payers to downcode, preventing denials must become an operational imperative. Our denials management experts note four things that providers can do to help reduce partial denials, and downcoded claims and DRGs:

- **Improve Clinical Documentation:** Have a specialized clinical documentation improvement (CDI) team for inpatient and outpatient to capture all appropriate documentation for every patient encounter, especially surgical procedures and inpatient admissions that relate to DRG downgrade targets like sepsis.

- **Focus on high-severity cases:** High-cost MCC and CC cases like malnutrition, respiratory failure, renal failure, and other severe conditions are downcoding targets and need to be the focus of the CDI program. Coders and clinicians need to work as a team to improve documentation for those types of conditions.

- **Create clinical treatment policies:** Providers need to be consistent about how they diagnose and code high-target cases like sepsis and be persistent in communicating to the plans that they have a uniform policy regarding clinical treatment and coding of those cases based on specific guidance.

- **Leverage your data:** Statistical analysis can deliver important insights into payer behaviors around denials and downcoding. Those insights can prove valuable when negotiating terms of the next payer contract or when dealing with arbitration or considering legal action to recoup revenue.

Deploying denials best practices

An ounce of prevention is worth a pound of appeal

Comprehensive clinical denials management is a game of both offense and defense. On offense, the healthcare provider does its best to code, bill, and submit clean claims that get prompt payment. Providers win by preventing denials and downgrades. On defense, the provider is protecting revenue by appealing denied claims and reinforcing appeals with evidence refuting the denial. While it takes both a strong offense and defense to effectively manage denials, prevention is generally the first and best step forward.

Identify denial risks to strategically deploy resources

With revenue at risk in multiple areas of reimbursement, denial prevention requires a holistic view of hospital operations, both clinical and administrative. Healthcare providers face a serious financial threat from the rise of targeted denials, so attention must be given to every revenue-generating department and service.

What is your most common denial type?

47% → Medical necessity
28% → Lack of authorization
11% → DRG downgrades
7% → Coordination of benefits
7% → Other

(Source: Online poll of 250 Becker's Healthcare webinar attendees)

Keep up to date with coding rules and regulations

With more and more physician practices being owned by health systems, the risk to coding and billing evaluation and management (EM) services is increasing. That may be remedied somewhat by new rules for hospital-based physician coding of their visits that went into effect January 1, 2023, but that jury is still out. It will remain important to teach physicians the new coding rules because not only can that reduce revenue risk, but it may also improve the overall quality of clinical documentation.

Focus on high cost and utilization targets

Always consider the care setting for a treatment or procedure as payers tend to favor ambulatory surgery centers for their lower cost and use that as a basis for denials if the same care is delivered in a hospital setting. Because of the very high cost of many oncology drugs, infusions are receiving more scrutiny from payers to ensure medical necessity, indication for the disease and even proper dosage. All infusion clinics should have oversight to ensure those things are reviewed for absolute accuracy. Imaging and labs are also high denials risk areas and should be monitored and analyzed to determine and correct root causes.

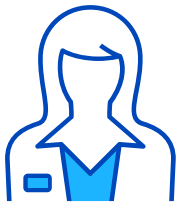
Monitor reimbursement to find revenue leaks

On the hospital side, we see the emergency department being targeted for denials with payers using automated facility fee downgrade algorithms. These don't appear as denials but as payment reductions, making them difficult to detect and correct if providers aren't monitoring for them. Keep an eye on evaluation and management services like observation units. Medicare has one set of rules for observation, while private payers use their own rules, so knowing which rule set applies really matters for revenue integrity.

Watch for strategic DRG downgrade targets

Looking at inpatient revenue risk as a payer strategy, successfully downgrading a DRG benefits payers by lowering the cost of other services tied to the lower weighted DRG. Long term acute care hospital (LTACH) transfers and acute rehab denials are also becoming more common. Especially with Medicare Advantage plans, there is pressure to not approve transfers to LTACH and acute rehab facilities. Psychiatric care services are also being closely scrutinized and should be monitored for denial trends and reasons.

Three types of medical necessity



Why the care is needed

Where the care is delivered

How the patient is classified

The three faces of medical necessity

With so many denials now based on questioning the broad term of medical necessity, it's important to know there are three types of necessity at play. First, can the physician prove that care was required and appropriate? This is where proper clinical documentation of diagnosis tied to recommended treatment pays dividends for preventing denials. Second is necessity of setting—can the service be performed with the same clinical outcome at a lower cost in a different setting like an ASC? If so, it should be. Finally, payers will look at necessity of status. If a patient can receive care as an outpatient rather than inpatient at a lower cost, that becomes the preferred option.

Build a team and give them the right tools

Knowledge is power, and the more you know about what's causing denials the better you can respond and defend your billed charges as medically necessary, clinically appropriate and correctly coded. This should start by doing a thorough root cause analysis of denials. Payers will deny claims for a wide variety of clinical reasons like medical necessity as well as administrative reasons like lack of prior authorization. But our data shows they tend to target certain diagnostic codes based on their own data analysis.

Because the causes of denials are so far ranging, the most important management best practice is to assemble a cross-disciplinary team of stakeholders to manage the process. The team should meet regularly to talk about denials trends, causes and prevention measures and ensure denials are being addressed in the most effective way.

Negotiate payer contract language to protect revenue

On the subject of managed care contracts, providers should make sure to negotiate as much favorable language as possible and never make any reimbursement requirement more rigorous or stringent than the prevailing regulatory guidance. Not every service is covered by every payer or plan, despite it being reimbursed by Medicare and Medicaid or approved by the FDA—ultimately reimbursement all comes down to the terms defined in each payer contract.

Creating a payer matrix is another best practice that can make appeals much more efficient. The payer matrix has rows for each payer and plan, and columns for essential information like filing timeframe, mailing address or portal location and first and second appeal steps. All those things in one place make it much easier to follow process and file those appeals in a timely manner.

Drive quality improvement with analysis and education

Perhaps the most important point to remember about managing denials is to always close the process loop with analysis and education. Root cause reporting gives the interdisciplinary team the information it needs to educate staff on processes and workflows needing improvements. Denials prevention and management really go hand in hand. Denials is an evergreen pain point for providers, so be sure that denials prevention starts at the beginning with front-end registration, proceeds through quality clinical documentation and always leverages a deep understanding of payers' requirements to get services approved and delivered.

Appeal like a lawyer: Legal principles for overturning denials

Denials have been on the rise for years and healthcare providers are challenged to keep pace. By learning basic legal principles, you can appeal smarter to significantly increase your odds of overturning denials and driving greater success for your denials management program. Appealing like a lawyer starts by addressing all denials with a P.L.E.A.—persistence, logic, exculpation, and advocacy.

Persistence

is a key characteristic of successful denials management. Failing to contest denials, especially those deemed inappropriate, opens the door for future audits and denials based on similar reasons. Never concede a denial – you always have recourse through negotiation, arbitration or legal action when appealing disputed claims.

Example denial #1	Appeal tip
The Provider gets authorization for CPT code 29823 (Arthroscopy w/ debridement) but bills CPT code 29826 (Arthroscopy w/ ligament release) and 23420 (Tendonesis) that are denied for lack of authorization. The Provider's appeal asks for an exception because they "neglected to get authorization for the two CPT codes."	It is common for authorized procedures to expand in scope and include additional or divergent CPT codes. In lieu of asking for an exception – which can be considered tacit acceptance of alleged error or neglect – stay firm and document the case supporting the CPT changes that could not be authorized in advance.

Logic

is the foundation for all successful appeals. Trust your instincts and use the smell test—if something seems wrong, it probably is. Rationally examine all aspects of a denied claim so you can determine the viability of an appeal. No matter how arbitrary or inconsistent a denial may be, applying logic to refute its allegations is your best strategy for success.

Example denial #2	Appeal tip
A Plan denied benefits to a child with cancer citing a provision that it does not have to pay a benefit if the patient would not have to pay that benefit. The original intent of the provision was to exclude payments to family-member caretakers who provide voluntary care at no cost, not hospitals and clinicians, and was therefore wrongly applied.	A Plan provision cannot be so distorted from its original intent to the detriment of the Provider. If the appeal goes to arbitration, you want to make your arguments more logical and aligned to contract intent than the reasons for denial.

Exculpation

means to free from allegation, to vindicate. It is the provider's task to exculpate by refuting the payer's allegations with persistence and logic. Many appeals end up being approved based on things the payer did wrong, so never accept denials at face value and look for the flaws in the payer's arguments.

Example denial #3	Appeal tip
A Payer denied a claim for Lack of Notification of an ER Admission, but the Contract states the Payer has to pay for the first 48 hours. The Provider files an appeal which is rightly denied as untimely. Should the Provider accept the denial?	In situations where the appropriate process was followed, advocate for reimbursement for your institution. Extenuating circumstances often exist depending on the factual scenario. People and situations are complicated, and information can often be incomplete or misleading. Documentation is key to supporting a convincing argument for payment.

Advocacy

is how to best represent your organization's interests. Not every denial is worth appealing, but those that are deserve your best effort to make and win the case. A good denials management program vigorously defends the necessity of medical care decisions through documentation, identifies root causes and adapts processes to reduce the risk of future denials.

Example denial #4	Appeal tip
A patient presented with insurance coverage in the ED. The organization performed due diligence and sought authorization from the insurer they believed to be primary at the time of admission. Weeks after discharge, the Provider discovered that the billed plan was not primary. Upon billing the responsible Payer, the claim was denied for a Lack of Authorization.	In situations where the appropriate process was followed, advocate for reimbursement for your institution. Extenuating circumstances often exist depending on the factual scenario. People and situations are complicated, and information can often be incomplete or misleading. Documentation is key to supporting a convincing argument for payment.

When it comes time to actually write appeals another formula, I.R.A.C., can be very helpful. This formula first examines the **issue** driving the denial, applies the **rules** governing the claim, **analyzes** the claim and denial, and offers a **conclusion** on why the appeal should be upheld.

Denials recovery use case

How a top cancer center recovered 74% of cash from denials

Challenge

A large West Coast cancer care provider shared a problem that many other hospitals and health systems also face—keeping up with moving payer targets and an ever-increasing denials workload. In addition, because of the unique nature of its patient population and cases, the provider wanted to optimize reimbursement from complex claims that can often be difficult to adjudicate and collect. After an objective evaluation it became clear to the provider that they could benefit immensely by finding a revenue cycle partner to help them overturn denials, provide root cause analysis and meet their cash goals.

Solution

The cancer facility began its search for a revenue cycle management partner through a request for proposal (RFP). In reviewing vendors, the center soon noticed natural alignment between their needs and the benefits that a true revenue cycle management partner could bring to their operations.

> Through the RFP process, we recognized the unique skill set R1 had to offer which included attorneys, nurses and other highly skilled individuals. Finding a vendor with a good reputation was a top priority. We did our research and found R1 was highly endorsed by professional organizations like HFMA and Becker's Hospital Review, and by leading healthcare providers. R1 has been reliable, trustworthy and a fantastic partner."

The medical center ultimately selected R1 Denials Recovery to help accelerate cash recovery and ensure accurate reimbursement, and R1 Complex Claims Referrals to streamline claims management for Veterans Administration (VA) and Workers' Compensation.

> In addition to converting denials into revenue, R1 truly became an extension of our revenue cycle team, regularly reporting insights to drive process improvements that lower the reality and risk of future denials."

Results

Since going live on R1 Denials Recovery and R1 Complex Claims in 2020, the medical center has been able to recover more than $68.5 million by reversing denials and streamlining complex claims processing. It exceeded its cash goal in 13 of the first 15 months since engaging with R1, days in AR have decreased, and collection rate has increased due to the high number of overturned denials.

> R1 helped us identify a carve-out issue for high-cost drugs that required a drug invoice when billed to Medicaid Managed Care plans. After implementing a claim edit to stop claims from going to the payer without the invoice, we've collected $400,000. That's preventative denials at its core."

The benefits don't stop with improving reimbursement and operational efficiency. Getting root cause insights from our team of denial experts, said the customer, has been instrumental in preventing future denials.

Results that matter

36,865	$68.5M	74%
calls made to payers	cash collected	cash collection rate

The advantages of partnering to manage denials

There are many rocky roads in the denials landscape that require expert navigation, and the dramatic increase of payer denials in recent years has only made the terrain more difficult. This has many provider organizations exploring third-party options for preventing and overturning fully or partially denied claims. While there are clear advantages to engaging a denials management partner, making the relationship successful in the long run begins with vendor evaluation. Key considerations in a thorough vendor evaluation include:

- **Opportunity assessment** – A pre-engagement Aged Trial Balance assessment will help determine the level of need and scope the expected return on investment.
- **Experience and expertise** – Look for a vendor team with diverse, specialized skill sets in both healthcare and revenue cycle, including attorneys; clinicians including physicians, physician assistants, and registered nurses; and credentialed coders.
- **Advanced analytics** – Leveraging powerful analytics technology helps prioritize appeal opportunities, streamline workflows and identify denial root causes.
- **Compensation model** – Straight fee-based compensation rewards the work a vendor performs while a contingency model rewards actual revenue returned to the client.
- **Overturn rates** – Compare time-to-payment and denial overturn rates of vendors and be wary of candidates unwilling to provide that data.

Strategic recommendations

Pay close attention to the base language in contracts

When contracting, most hospitals and health systems focus mainly on rates, while not looking closely enough at the actual verbiage going into a contract. This oversight has the potential to open health systems to impromptu audits, denials and contract changes. For example, hospitals can protect themselves by including language around administrative denials. Keep contract language as black and white as possible to avoid any areas for potential exploitation. Providers can have the best rates in the world, but if contract language doesn't protect them, payers will come back and continue to deny or retake funds time and time again.

Use payer scorecards to ensure accountability

Payer scorecards are a beneficial tool to help providers analyze and understand payer performance. These scorecards offer valuable insights into payers as providers evaluate collections and yearly performance. In a scorecard, look for sudden payment fluctuations and current market trends, and note how they stack up against industry benchmarks. This will help not only hold payers accountable, but it will also help in future contract negotiations.

Scrutinize Emergency Department downgrades

To help avoid downcoding that comes from ED level-of-care denials, particularly on lower balance accounts, be diligent in documenting why patients are moved up in their ED level of care. Also, pay close attention to these denials when they do happen, so staff can appeal before it's too late.

Keep an eye on Medicaid/Medicare crossover patients

New rules mean hospitals will no longer be fully reimbursed for bad debt coming from Medicare/Medicaid crossover patients. Given the recent Medicaid unwinding efforts, organizations serving high Medicaid populations could leave behind thousands of dollars on the table. Teams like those at R1 can help hospitals report on these crossover patients correctly, particularly with the Medicare Cost Report, so health systems can recoup as much of these funds as possible.

Put a focus on forensic audits of high-balance claims

Many payers request itemized bills on high-balance claims, removing specific lines they feel are already bundled into other areas of the bill. A good example of forensic audits on high-balance claims is room and board charges. Payers are starting to look at specific charges for items like saline and saying you can't charge separately for that as it's all bundled into room and board. As a result, they are pulling that out of the total charges, which decreases the reimbursement. To ensure these smaller underpayments don't fall under the radar, dig into any reasons for lower reimbursements, so staff can explain why certain charges should be reimbursed separately.

Link hospital and physician data

While electronic health records (EHRs) are becoming a common place to store hospital and physician data, these data sets can be siloed or fragmented from one another. Integrating facility and provider data sets can optimize revenue recovery by capturing missing charges, coding errors and improving compliance and process. There are key measures providers can take when linking this data, including comparing data sets to identify more reimbursement opportunities, making sure clinical documentation is on point and analyzing cross-linked data to ensure greater revenue integrity.

Choose a partner with a global footprint

It is imperative to get in front of payers and stay on top of the adjudication process. Leveraging a partner with a global footprint can help health systems follow-up with claims more quickly and seamlessly, keeping AR days down and preventing increased denials and downcoding tactics.

Having a global footprint means a providers' workforce arm is multiplied, helping the organization hold payers accountable and avoid falling victim to market challenges. A trusted RCM partner can be an extension of your team and more proactively follow-up on delayed or denied claims, helping providers capture fuller and expedited payments.

Conclusion

Mastering denials management is no easy feat, but with the right resources it can completely transform operations. We welcome a chance to talk about how we can help with your organization's personalized needs, including how we can help minimize future denials, resolve claims more quickly and boost workflow efficiency.

We can help audit your current RCM processes for growth opportunities. Get in touch at contact@R1rcm.com.

R1 is the leading provider of technology-driven solutions that transform the patient experience and financial performance of hospitals, health systems and medical groups. We are the one company that combines the deep expertise of a global workforce of revenue cycle professionals with the industry's most advanced technology platform, encompassing sophisticated analytics, AI, intelligent automation and workflow orchestration.