



## Commercial Denial Management by Julia Carter

Many hospitals depend on a large part of their reimbursement from federal programs such as Medicare or Medicaid. It usually follows that much of the denial management focus is on these programs. However, when the payor mix is 10% or more of commercial payors, there is a real opportunity to impact the bottom line by preventing and managing commercial denials. This article will detail some of the most common instances and will suggest steps to prevent, reduce or eliminate these denials.

Let's begin at the beginning: verify benefits, including deductible, co-pay and coinsurance, in as much detail as possible *before service is rendered*. This process can be in place at several different points during scheduling and pre-registration and has the greatest impact on a variety of denials. Applying to deductible, coinsurance or co-pay can't be prevented, but knowing this ahead of time can aid in up-front collections and preparing the patient for the balance due.

No coverage, coverage not in effect on date of service, before coverage or after coverage, ineligible or no dependent coverage can all be avoided completely by accurate and timely verification of benefits. No coverage can be addressed immediately by contacting the patient for the correct insurance information or determining that the patient is eligible for Indigent Care or Charity funding.

Denial	Prevention/Solution
Patient has no insurance coverage	<i>Upfront verification of benefits</i> ; documentation in system; contact patient via phone/email/letter/billing; remove insurance from account after denial is posted
Service is before/after termination date	<i>Upfront verification of benefits</i> ; documentation in system; contact patient via phone/email/letter/billing; remove insurance from account after denial is posted
No dependent coverage; ineligible dependent	<i>Upfront verification of benefits</i> ; documentation in system; contact patient via phone/email/letter/billing; remove insurance from account after denial is posted

Upfront verification of benefits can create opportunities for good customer relations, too. Many times new parents fail to sign up the latest addition to their family before your claim has been filed. When this potential dependent coverage denial is discovered, it's worth some extra work to contact the insured parent to assist with this process. You not only insure your payment, but also generate good will for your facility.

Pre-certification or authorization clearly belongs on the front end of a patient's visit, but requires a constant and open flow of communication between



registration, Utilization Review and/or clinical certification, billing and denials management. Payors are requiring prior authorization on an increasing number of procedures and keeping up with the requirements can be a challenge. Creating a simple spreadsheet or database can be an easy way to track requirements by procedure or by payor. Having all the necessary information in a central location such as a shared network drive and making sure that the right people have access are also important. Don't underestimate the benefit of a simple shortcut to the file on a desktop. Making such tools *easily available* is key to their usage.

Utilizing the procedure- or appointment-specific rules in Community-Wide Scheduling can also be a powerful ally in making sure that necessary procedures

Denial	<i>Prevention/Solution</i>
No pre-certification/authorization	<i>Upfront verification of benefits; documentation in system; use CWS rules or 3<sup>rd</sup>-party vendor; appeal ASAP</i>
Duplicate Claims	<i>Evaluate current automatic rebilling processes; review accounts prior to requesting a rebill; insure that original denials/EOB are being posted</i>

are certified in advance of the service. Evaluate whether a third-party vendor product that builds rules into MEDITECH can enhance this process for you.

Have an appeals action plan in place that begins as soon as a denial is received. Many payors have a short turn-around for appeals, so time is of the essence. Include a review of the entire pre-certification process in the appeals action plan to determine why certification was not accomplished prior to service to see if you have a breakdown at any point.

Document verification and authorization information on the account by using the standard fields in Meditech ADM or ARM or create a Customer Defined Screen with additional fields. These can be used instead of a paper form so that the information is readily available throughout the life of the account. Compare the payor explanation of benefits (EOB) to the verification to insure that the information matches. If there are any discrepancies, contact the payor for more information.

A Customer-Defined Screen might look something like this.



Precertification			
OR Procedure:	<input type="text"/>		
Insurance Contact Person:	<input type="text"/>		
Insurance Contact Phone Number:	<input type="text"/>		
Doctor's Office Contact Person:	<input type="text"/>		
Verification/Benefits			
In Network Deductible:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
In Network Out of Pocket:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Lifetime Max:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Out of Network Deductible:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Out Network/Out Pocket:	<input type="text"/>	Met: <input type="text"/>	Pays: <input type="text"/>
Pre-Existing:	<input type="text"/>	Co Pay: <input type="text"/>	
Allowed Visits Per Year:	<input type="text"/>	Visits Applied to Policy:	<input type="text"/>
Insurance Contact Person:	<input type="text"/>		
Insurance Contact Phone:	<input type="text"/>	Date Contacted:	<input type="text"/>
Insurance Contact FAX:	<input type="text"/>		
Comment:	<input type="text"/>		

Denials for duplicate claims may mean that your billing clerks are spinning their wheels trying to collect on accounts that are already paid or applied to deductible, etc. This denial also causes extra work on the denial management side. Do you have automatic rebilling processes in place that need to be tweaked? Are your billing clerks properly reviewing accounts before demanding a rebill? Are the original, legitimate denials being misplaced or not posted to the account? Cleaning up these processes can add to up to more time spent on legitimate unpaid claims.

Keep the MIS insurance dictionary and/or claims clearinghouse files up to date with current underwriters for group plans and addresses for all plans. If a major employer changes plans, filing claims to the old underwriter will slow down reimbursement and cause unnecessary denials. Educate registration staff on how to choose the correct insurance plan and include them in the changes. Choosing the right plan with the wrong address practically guarantees that a claim will be delayed and/or denied. Making sure that the edits on an account in ADM or BAR are carried into the MPI will insure that future patient visits are filed correctly.

Also consider using Meditech's contract, benefits and verification routines for HMO, PPO, POS and OTH insurance plans.

Once a denial is received, making the same correction to other existing accounts may seem time-consuming in the short term, but can produce long-term benefits. If a claim is not already in the payor's denial sequence, sending a corrected claim will gain you a speedier reimbursement as well as lower denial numbers.

If you see the same denial more than a few times from the same or varied payers, it may be time to make a permanent correction in your claims program, whether it's MEDITECH or a clearinghouse. Eliminating the problem is one of the best ways to reduce overall denials and speed up collections.

Many payors routinely ask for information from the insured such as coordination of benefits or accident details, which means your claim is not being paid. Have a series of letters or phone call scripts created that can be sent to the insured



referencing the specific information that the payer is requiring. Many patients don't fully understand the requests that they receive from their insurance company, so they appreciate help from the provider. You can get a quicker reimbursement as well as create a good public relations image when you can assist early in the process rather than demand at the end.

Requests for additional information from you such as medical records can delay your payment drastically. When a payor routinely requests additional records, especially if you have a contract or agreement with the payor, negotiate a change in their process and see if you can send records with the initial claim, thus avoiding a delay. Have a good working arrangement and communication with the HIM department to insure that these requests are handled in a timely manner. Payor-specific coding requirements can be handled through custom claim checks in MEDITECH or through edits in your claims clearinghouse.

Contractuals are generally accepted as a way of life. The amounts of contractuals can vary, though, so don't take for granted that the payor adjustment is always correct. Verify that the contractual adheres to the contract agreement. Base MEDITECH proration rules on the contract and review regularly.

Capturing denials begins with using MEDITECH's Remit Code dictionary in BAR. Create remit codes and post them on accounts, either manually or electronically. NPR reporting, BAR compiled reports, a spreadsheet, data base or a third-party vendor's denial management product are all tools that can be utilized separately or together to find, report and manage denials.

E/E Remittance Codes

Insurance

Code

Active  Name

Send Remittance Code to ABS

Description

-Remittance Actions-					
Action	Canned Txt	Letter	Text	Rem Delay	
1	COMMENT	DEDUCT			
2					
3					
4					

Many remittance codes for commercial denials can be addressed with the EDI claim adjustment codes, but may require "home-grown" codes that are created because of payor-specific denials. These will also require mapping for the electronic remittance program as well as mental mapping for manual posting.



Generating a comment or reminder on the account is the most effective way of

Capturing Denials	Process
Remit Code Dictionary	Create remittance codes; use standard EDI codes when applicable; create payor-specific only when necessary; post manually or electronically to patient accounts
NPR Reporting	Intermediate NPR skills necessary (verify that MEDITECH is populating remit code DPMs)
BAR Compiled Reports	zANY REMIT CODE; zREMIT CODE DTS; zTXN REMIT CODE (ask MEDITECH for these)
Spreadsheet or Data Base	For use in manipulating, tracking, trending data from posted remit codes; review by type and by payor
3 <sup>rd</sup> Party Vendor Product	Can be interfaced to MEDITECH or written in MAGIC programming

recording the remittance code information. The letter selection attached to the remittance code routine cannot be tied specifically to the denial insurance plan.

The sheer numbers of denials can be daunting, even for the most determined. Review denials regularly and look for trends by denial type or payor. Working on the top five high dollar or high number denials will help to make this manageable and less intimidating. Making one or two process changes at a time is less stressful and more easily remembered for staff, too. Remember, each step you take in addressing Denials will pay you dividends in the long run.