

Avoidable Technical and Clinical Denial Write-Off Management in Hospitals, Physician Offices, and Clinics

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ABSTRACT

Purpose/Objectives: This article reviews the various types of technical and clinical denials that are usually “written off” and proposes strategies to prevent this loss. For purposes of this writing, avoidable technical and clinical denial write-offs are defined as revenue lost from “first-pass” denials rejections. For example, a procedure that requires an authorization is performed without having had an authorization obtained. After appeals and attempts to recoup the revenue, often unsuccessful, the organization ultimately “writes off” the revenue as not collectable. The question to ask is: Are these claims really not collectable or can actionable steps be taken to conserve these dollars and improve the bottom line?

Primary Practice Setting: Acute care hospitals, physician offices, and clinics.

Findings and Conclusions: In today’s environment, the need to manage costs is ubiquitous. Cost management is on the priority list of all savvy health care executives, even if margins are healthy, revenue is under pressure, and the magnitude of cost reduction needed is greater than what past efforts have achieved. As hospitals and physician clinics prioritize areas for improvement, reduction in lost revenue—especially avoidable lost revenue—should be at the top of the list. Attentively managing claim denial write-offs will significantly reduce lost revenue.

Implications for Case Management: There is significant interface between case management and the revenue cycle. Developing core competencies for reducing clinical and technical denials should be a critical imperative in overall cost management strategy. Case managers are well placed to prevent these unnecessary losses through accurate status determination and clinical documentation review. These clinical professionals can also provide insight into work flow and other processes inherent in the preauthorization process.

Key words: case management and clinical denial, claim denial, clinical denial, lost revenue, revenue cycle, status determination, technical denial, write-off

Claims submitted by health care-related organizations come under closer scrutiny every year. New regulations, guidelines, and requirements levied by the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General, and other auditing entities, including those for Medicare and Medicaid Health Maintenance Organizations, are affecting hospitals and physician offices revenue. Additional pressure is brought to bear by Value Based Purchasing, tenets of The Affordable Care Act, and the advent of Accountable Care Organizations and Medical Homes. These factors join forces in creating a treacherous financial landscape that is constantly changing and challenging to negotiate. An often-overlooked source of financial vulnerability is clinical and technical claim denials. These claims, and the resultant loss, can be difficult to quantify and qualify,

but the impact of avoidable technical and clinical denial write-off is plaguing hospitals and physician clinics across the country.

What are these “write-offs,” and how does a conscientious organization get to the bottom of this hidden financial drain? Furthermore, once an organization identifies the problem, how does it prevent further losses and then defend the right to reimbursement as billed? To understand the issue, one must

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Clinical documentation systems might be separate from accounting systems, which are different from claim processing and coding systems. These disparate data systems may or may not speak to each other. Although efforts are made to help these systems communicate with each other, the ensuing data may be wholly inadequate to pinpoint denial write-offs as the software that populates the claim cannot speak to the system that houses the reimbursement information. This communication gap is just one of the challenges facing organizations when they start investigating where the denials are.

first have some basic knowledge of how health care organizations collect, store, and retrieve information. The answers can be surprising.

Today's health care organizations typically lack the infrastructure that will provide a clear picture of the avoidable write-off landscape. Is this surprising? Not really when legacy systems are taken into account. Legacy systems are large, old software programs that have evolved over the years with "enhancements" that may or may not be documented. Clinical documentation systems might be separate from accounting systems, which are different from claim processing and coding systems. These disparate data systems may or may not speak to each other. Although efforts are made to help these systems communicate with each other, the ensuing data may be wholly inadequate to pinpoint denial write-offs as the software that populates the claim cannot speak to the system that houses the reimbursement information. This communication gap is just one of the challenges facing organizations when they start investigating where the denials are.

A second factor contributing to the difficulties associated with identification, resolution, and prevention of technical and clinical denials is the generally limited cross-departmental communication about these write-offs or what causes them. Improved, informed communication can drive change across an organization that can lead to reducing these denials. Many processes are interdependent on communication between partners in the care delivery system: inside the organization (hospital or clinic) and partners outside the organization.

The complex nature of the prior authorization process for elective surgery is one example. This process involves the physician office, hospital registration, multiple hospital departments, and the third-party payer. Organizations that successfully overcome this communication challenge do so through the efforts of empowered teams.

Organizations may not have appropriate support in place to manage many of the clinical denials. Clinical denials are often a result of inadequate documen-

tation on the part of the physician, failure to provide supporting medical necessity components required under national and local coverage determinations, or lack of understanding of medical necessity guidelines. The appeals process put into place to combat these denials frequently reside in the business office. Individuals responsible for this process are seldom clinically trained.

We explore these three issues in more detail in an effort to better understand challenges and provide guidance for successfully addressing this complex opportunity to identify, prevent, and appeal these denials.

ENACT CHANGE THROUGH AN EMPOWERED TASKFORCE

A first step, once you have decided that investigating potential avoidable write-offs is essential, is to build an empowered team or taskforce to own the opportunity. The team tasked with this initiative must be composed of technical experts with specialized knowledge to cover and explore all bases. Who should be included in that team? The selection of members is driven by the setting: hospital or physician office or clinic. Here are some suggestions for team membership. (This should be modified on the basis of responsibilities, not position titles.)

The Technical and Clinical Denial Initiative Team

In the hospital, areas of responsibility are generally standardized and there is a large enough scope that there will be managers or directors in each of the following areas. Remember that a manager or director may not be your best option. Often, a line worker has special insight into processes and potential fixes.

It is more difficult to speak to what is "usual" in a physician clinic. The following responsibilities may be held by one person, clinic or office, or held by multiple managers across several sites. Depending on the size of the organization, front-end functions such as registration, scheduling, and precertification/

authorization may be centralized or spread out across each clinic. If not centralized, management from all sites should be included.

Roles and responsibilities are not always aligned with specific position titles. A team, once pulled together, should have the skills and knowledge to address both clinical and technical denials. An example of a Technical and Clinical Initiative Team membership is outlined in Figure 1.

ROAD MAP TO SUCCESS

Now that you have your team together, the next step is to define a process to identify opportunity inherent in reduction of avoidable write-offs. Many process-mapping methodologies are available that may help an organization map its processes. Once the method is determined and the process steps are outlined, taskforce members can map the process from Step 1. Depending on the size of the team, you may wish to engage in this exercise as a group. The idea is to identify each step in the process so you can readily identify hand-offs and other vulnerable actions that can lead to process breakdown. Your team may also find it helpful to shadow the process to gain first-hand knowledge of the flow.

The second step involves assessing the type and sources of data available to the team. Ideally, reporting will be automated and provide an executive-level overview of the write-off landscape as well as more detailed information and/or charts that can help

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pinpoint trends. It is unlikely that you already have a report that clearly identifies the many types of write-offs. If your organization is like most, you will have a lot of data but little information. The key is to turn the data into a useable, consistent, and reportable form.

Your team should begin by listing all of the data sources (e.g., financial reports, utilization reports) that contain the pieces of information you need to build a program of denial write-off reduction. If data sources are limited, utilize any data points available. The goal is to identify reports or data sources that can be used or manipulated to develop and implement tool(s) for reporting and management. Figure 2 is an example of what a write-off trending graph can look like.

The following types of denial write-offs should be considered when reviewing your data and when documenting processes. Look specifically for connections between process and results. For example, if you have a number of prior authorization

TECHNICAL and CLINICAL INITIATIVE TEAM MATRIX			
Specialized Knowledge	Denial Focus Area	Denial Type	
		Clinical	Technical
Leadership	Technical		*
Physician representation	Clinical	*	
Reporting/data	Analytic Report		*
Registration, Scheduling Preauthorization and Authorization	COB/Eligibility, Authorization and Precertification		*
Utilization Review/Case Management	Medical Necessity	*	
Clinical Documentation	Medical Necessity	*	*
Coding, billing collections	Invalid, missing, miss-matched or sequence issues, Timely filing		*

FIGURE 1
Technical and clinical initiative team matrix.

Total Write-Offs by Category – Most Recent 12 Months

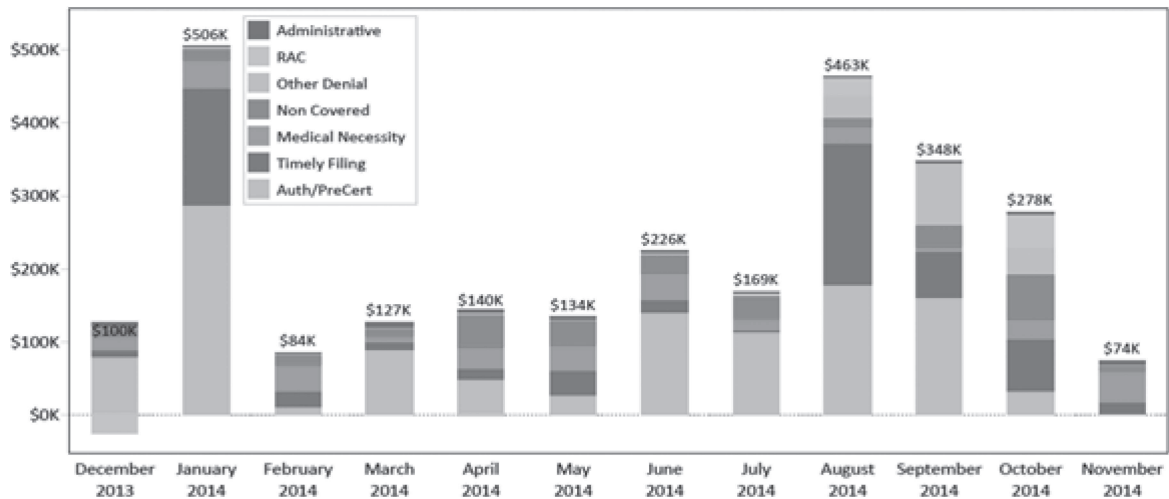


FIGURE 2

Denial write-off by category. From Berkeley Research Group (2014). Reprinted with permission.

denials, that process is probably broken and needs to be examined.

Authorization/Precertification-Related Issues

Inpatient.

This is an area that can easily result in what is considered a clinical denial for failure to notify or obtain precertification or authorization. Usually, three departments will be involved in this process: the patient registration department, utilization or case management, and the billing office. Each department has a role. We will take each action separately.

Failure to Precertify.

Procedures, home services, durable medical equipment, and elective hospitalizations often require precertification or prior authorization. Specifics are particular to the insurance contract and benefits available to the member. The physician's office is generally the source of generating the precertification, as evidence of supporting clinical documentation is typically required. This (precertification/physician office/clinic) is an area where breakdown of processes occurs. It is an important focus for those managing clinical denial write-offs.

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In the current environment of the Medical Home, many offices are putting case managers or nurse navigators in place. These individuals assist high-risk or high-cost patients in accessing the health care system. It may fall to these case managers to obtain precertification for outpatient or planned, scheduled inpatient services. Placing this function in the hands of clinical personnel may reduce the overall denial for lack of precertification, as well as accurately identifying those procedures that are considered "inpatient only" by the CMS (see Figure 3).

Failure to Notify.

Once the patient has been admitted to the hospital, there is generally a requirement to notify the third-party payer and in most facilities this is done by patient registration staff. No rule states that patient registration staff has to do the notification, but tight notification timelines often have to be met. Because of the contractual obligations, and the significant financial risk that comes with failure to comply, the first interface between the patient and the hospital, which is patient registration—is typically tasked with notification of the third-party payer. Again, this is an area where poor communications and process breakdown can occur, resulting in a technical denial, as it is directly related to a process.

This is also an area where case management or utilization review can have a significant impact. Often, contractual requirements to notify exist for inpatient level of care services but not for outpatient observation (other than what may require precertification). It becomes imperative that cases be reviewed promptly to determine the status—inpatient or outpatient observation—and the appropriate individuals notified. It is becoming increasingly common to

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have notification requirements 7 days a week. This can be very challenging when case management is not staffed adequately or even at all on weekends and after normal business hours. Review your commercial (third-party) payer agreements to determine what responsibility your organization has.

Authorization Not Obtained.

Frequently, clinical documentation is required by a third-party payer prior to authorization of services. Failure to submit this documentation can result in claim denial. It is important that the department responsible for submitting this information fully understands the notification parameters required in the contract between the third-party payer and the hospital. Process breakdown and poor interdepartmental communication may occur.

There needs to be a close working relationship between those who are providing initial notification to third-party payers and those who are providing the follow-up, clinical information. Notification that the patient presented is not enough. Although an “authorization” number may be supplied, this does not mean that the services will be covered. Usually there

is a caveat of “medically necessary” or other such language attached to the authorization number. Only the clinical documentation can establish medical necessity. The burden is generally on utilization review personnel or case management in an integrated program to provide this documentation. Again, it is important to understand the contractual parameters under which notification and clinical documentation are provided.

Outpatient Services

Many scenarios can result in outpatient technical write-offs. In addition to the issues discussed previously, denials specific to a clinic may occur. Examples include inadequate missing authorization on reoccurring series treatments, expired authorization due to rescheduled encounters, and mismatches between what was ordered and authorized and what was actually performed and billed. Work to map the processes and identify areas of vulnerability.

Noncovered Services

Quantify the volume of denials received as “non-covered services.” Investigation may show that the service actually is covered; it has simply been billed incorrectly or with improper code sequencing. Non-covered denials and write-off research can be tedious, but they are necessary and can be quite fruitful. Look for patterns in dollar denial amounts. The assistance of a person with clinical training, such as the case manager or utilization review staff, can be helpful as it will bring insight into what is, and is not, typically covered and considered standard of care.

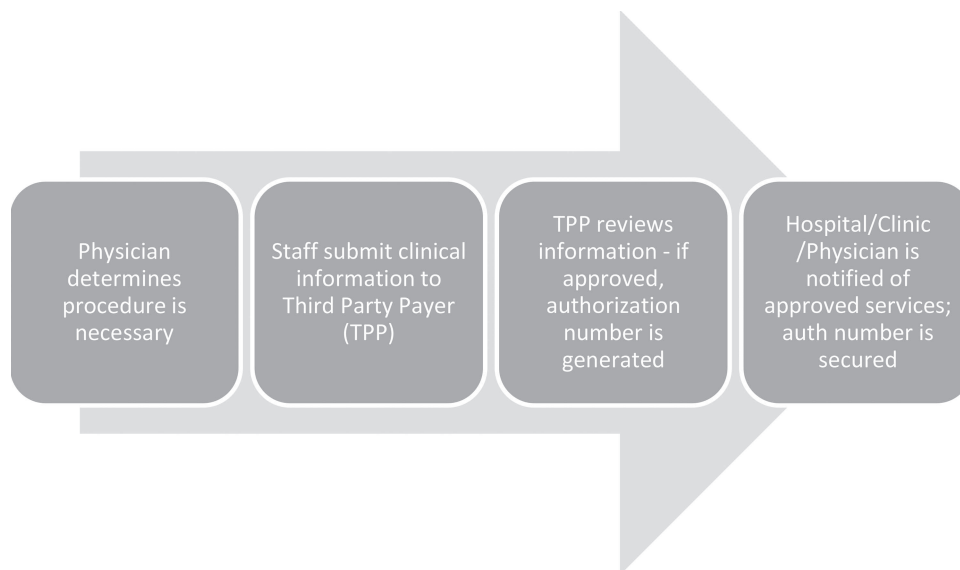


FIGURE 3
Precertification process.

SUCCESS STORY 1

Clinic A— Noncovered

Of Clinic A's 2014 fiscal year write-offs, 28% were written off because of the services being noncovered. To gain an understanding of this population, account-level transaction detail was obtained and organized, on the basis of the referring physician. The providers with the highest write-off amounts were sampled to identify the root cause of the write-offs. Based on sampling, it was determined that a large percentage of the noncovered services were due to nurse practitioners (NPs) or physician assistants (PAs) acting as first assists in surgical procedures for which Medicaid or Medicaid products were the carrier. In the state in which these clinics are located, NPs and PAs are not covered as surgical first assists. As a result of the findings, NP and PA utilization was modified so services were strategically scheduled to maximize the NP's and PA's covered surgical assist time, as well as the time previously spent assisting in the office as a physician extender.

Inpatient Only Procedures

These types of denials can be classed as either technical or clinical. Each year, the CMS produces Addendum "E," a list of procedures that it considers "inpatient only." The CMS will reimburse only at an inpatient level of care and only if the procedure was performed prior to an inpatient status order being written. Review of the surgery schedule and identification is often a shared responsibility between patient registration and a clinical department, such as case management. The clinical person can provide insight into the procedures and the possibility of a resultant code being on the inpatient-only list.

The CMS has recently changed its policy requiring a physician order written prior to an "Inpatient Only" procedure being performed. Transmittal 3217 states, in part:

Effective April 1, 2015, inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding

the date of the inpatient admission that would otherwise be deemed related to the admission, according to our policy for the payment window for outpatient services treated as inpatient services will be covered by CMS and are eligible to be bundled into the billing of the inpatient admission. (Department of Health and Human Services, 2015, Transmittal 3217)

Prior to this change, "A surgical procedure on the Medicare inpatient-only list that is not ordered in the correct status prior to the commencement of surgery will not be able to be billed to Medicare and represents a revenue loss to the hospital" (VanGelder & Coulter, 2013, p. 113). Physician orders such as "admit to pre-op" will be considered an order for outpatient level of care and will not be billable as inpatient, so close monitoring of these cases is still required.

As with any function for which there is dual responsibility, communication is integral to capturing these procedures and eliminating this write-off type. You may find these claims categorized as medical necessity or noncovered service denials.

Experimental Services

Experimental services are generally services that a payer—commercial or government—deems as experimental and, as such, are not eligible for reimbursement. These are readily identifiable and generally speaking, easily reducible. This potential write-off can be listed under noncovered services, medical necessity, or experimental. A guide to the coverage limits for these services can generally be found on a payer's website.

Inpatient Medical Necessity

"Medical necessity" is a term used to describe certain clinical services documented and delivered at an appropriate level of care. Claim payment is often denied with a reason of "not medically necessary" attached but the services may be quite medically appropriate. This particular denial type may mean that components of national or local coverage determinations are not found in the record, that

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documentation does not support medical necessity, or that although medically necessary, the care could have been delivered at an alternate level, such as observation. Be prepared for a variety of underlying, actual reasons for the denial and potential write-off. Case management or utilization review staff are appropriate to assess elements of the medical record that will constitute medical necessity documentation.

Outpatient

Medical necessity denials for noninpatient claims are more technical in nature and typically stem from process breakdowns in the patient access/registration areas. Triggers in this area can be traced to failure to complete coverage check steps, such as those involved in an Advance Beneficiary Notice process for CMS beneficiaries and proprietary systems for commercial payers. Often, staff is dependent upon a cumbersome identification system, and the incidence of write-offs can be unrecoverable.

Recommendations

- Confirm what tool, if any, is being utilized to complete the medical necessity checks.
- Determine key areas where the highest volume and/or dollars are being denied for “technical” medical necessity.
- Determine the practice/process for validating medical necessity.
- Determine what feedback loops, if any, exist to correct medical necessity denials and avoidable write-offs.

Timely filing

This type of write-off is typically caused by a process breakdown in one of two scenarios: (1) the claim simply was not billed to the payer within the contracted filing guidelines or (2) the account was not processed

in terms of additional information, rebill, or other work within the timeline required. Understanding where the processes break down and finding solutions can positively impact the volume of “Timely Filing” write-offs.

Items to consider

- Who is responsible for working claims if there is a billing edit?
- Is the workflow prohibiting claims from being identified as needing updates?
- How is the work prioritized? Is there enough staff to work all of the claims on hold? Are they reviewing and/or holding too many claims?

SUCCESS STORY 2

Hospital A—Timely Filing

Of Hospital A’s avoidable write-offs, more than 50% were due to timely filing. With such a high percentage of denials being related to a “process,” a team was formed and investigation began. Data containing all current claims for patients who were discharged but not final billed were reviewed. Interviews of the Revenue Integrity Team, as well as the Business Office, Health Information Management, and Patient Access Managers were conducted. Additional interviewees included claims processors, patient registration, and medical records staff. These interviews were conducted to gain an understanding of the billing process—from patient discharge to the bill arriving at the insurance carrier. During the interviews and data review, it was discovered that a significant population of claims were being held in “prebill” edit status and were stopped in the hospital claims system. Although this is a typical step in the claim process, the hospital had recently installed a new claims processing system and as part of the new design; this “prebill” edit structure was created but never assigned to specific departments or individuals to review, correct, and release. As a result, these claims were never billed to the carriers. A taskforce was created to work the backlog of claims, establish a process going forward to manage the “prebill” edits, and monitor the population of claims at risk of becoming untimely. The result of the improvements reduced the “prebill” population from \$120 million down to \$35 million.

Sifting Through the Data

Now that you have established a dedicated team, mapped your processes, and reviewed your data sources, you should have a good idea of what is available for use or how that information might pull the

HFMA Hospital and Health System MAP Award
<p>Measure:</p> <p>Cash Collection as a Percentage of Adjusted Net Patient Service Revenue</p> <p>Purpose: Trending indicator of revenue cycle to convert net patient services revenue to cash</p> <p>Value: Indicates fiscal integrity/financial health of the organization</p> <p>Equation: N: Total cash collected D: Average monthly net revenue</p> <p>(Healthcare Finance Management Association website, n.d.) http://www.hfma.org/Content.aspx?id=13635</p>
HFMA Physician MAP Award
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FIGURE 4

HFMA MAP Keys. From Healthcare Finance Management Association website (n.d.) Retrieved December 17, 2014, <http://www.hfma.org/Content.aspx?id=25645>. Reprinted with permission.

data together to create a usable report. The next step in the identification process is to learn what is causing these denials.

Identify a way to summarize the denial and write-off populations through raw data manipulation. Create a set of standard “major rollups” for first-pass denials and write-offs. For example, group all denial codes that are related to coordination of benefits together, or group all write-off reasons together that are specific to authorizations. Once the data are summarized by reason, begin looking for trends. A few basic ways to organize the data are listed later.

Write-offs by Department or Location

Organizing data by department or location can show what departments are missing the mark with appropriate registrations or could use more training or support when it comes to authorizations.

By Physicians

This view can be especially useful in an environment where there are multiple physicians, such as in a

clinic setting. The larger the physician practice, the more difficult trend identification can become. Summarizing data by the referring physician can pinpoint physicians who consistently perform services that are not being reimbursed or, for some reason, are being denied. If write-offs are summarized by physicians, trends may be identified through pattern detection, known as understanding the “like balance” write-offs. An example might be identifying 50 claims all with a write-off of \$275.15. These are known as “like balance” write-offs and typically are a result of the same claim payment logic.

CONCLUSION

Create a team, as depicted in the Team Matrix as shown in Figure 1, with both clinical and technical expertise. Identify process breakdowns within the organization that lead to denials and avoidable write-offs. Assign account-sampling responsibilities and determine the areas of vulnerability. Once the cause is determined, create a solution—a process or procedure that will

reduce or eliminate the issue causing the denial or write-off. Meet regularly to discuss sampling results, next steps, and outstanding tasks to be completed from prior meetings.

Measurement Benchmarks

The Healthcare Financial Management Association (HFMA) is a nonprofit membership organization for health care financial management executives. The HFMA is the nation's leading membership organization of health care finance executives and leaders. The HFMA MAP Awards recognize health care organizations that achieve excellence or demonstrate substantial improvement in revenue cycle performance. Some examples of the MAP Awards offered by HFMA are given in Figure 4.

IMPLICATIONS FOR CASE MANAGEMENT

As health care regulatory constraints grow, and the reality of health care economics continues to impact revenue, more burden will be placed on the processes and people employed to protect the organization's bottom line. Case management is positioned as the standard bearer, creating an interface between the clinical and financial worlds. Although a sometimes-daunting position to be in, case management can help make or

break an organization—certainly, when addressing clinical, and sometimes technical, claim denials.

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