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Managing Insurance Denials

by TINA CLARK

The key to reducing denials is to correct whatever would cause the claim to get denied prior to the claim being produced. In addition, it is important to ensure denials that are received are investigated and resolved promptly.

Oftentimes, a hospital's Patient Financial Services (PFS) staff is engulfed by futile attempts at denial management. Most PFS departments are so overwhelmed with getting claims out the door and performing follow-up at least one time that they have no time to then manage the rejections they receive. Facilities that recognize PFS cannot "do it all" have created Denial Management Teams or Task Forces. These groups are blossoming in hospitals concerned about the growing number of denials they receive. The team or task force is comprised of not only financial staff but also clinical personnel who are all-important to identifying and resolving issues surrounding denials.

After a facility becomes aware of the denials that are causing mediocre cash collections and develops a team to reduce the denials, the next step is to charge the team with researching and resolving claims. They will identify the reasons claims are denied, track said reasons, and put a methodology in place to resolve the rejections within the facility's control. To do this, the team must start by developing key indicator performance monitoring and, most importantly, by setting a goal for denials acceptable to hospital management.

Where does the problem with denied

claims begin? Most people think it starts with PFS. In actuality most, if not all, denials begin at the point the patient is scheduled and pre-registered. The data gathered at the point the patient makes first contact with the facility is key to ensuring the claim that is billed is "clean" and reimbursed properly.

Therefore, a key indicator to track is the accuracy of the registration data obtained from the patient as entered into the facility's computer system and the manner in which the data is then reflected on the Universal Billing Form (UB-92). The team should follow step-by-step what happens to the information that was obtained from the patient as the information travels through the computer system to the final claim production. The team should also review what happens after the claims are sent to the insurance company for reimbursement and finally monitor the payment received.

Recurring errors will quickly unfold from the tracking established. The statistics compiled from the inaccuracies should be used to improve processes, implement training, utilize information data systems more effectively, and in the end remove the inconsistencies that lead to denials. The team should also work together to ensure complete investigation of variances on partially paid claims. A partial denial is as important to prevent and recover as a full denial. Two-thirds of all payment variances are usually attributed to underpayments.

Denials can be managed and successfully reduced. The Denial Management Team needs to stay focused, understand the process of claim production, and track the key indicators frequently.

Tracking and measurement, used as accountability, leads to good management. Using the key indicator tracking will allow facilities to measure and manage the denials being received from claims submitted.

The facility's success in reducing denials depends on the methodology used to measure data integrity and accuracy of claims sent to the insurance company for reimbursement. The attention to denial management should not wane, as the results could start to erode processes slowly, leading to big financial issues for a healthcare institution.



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