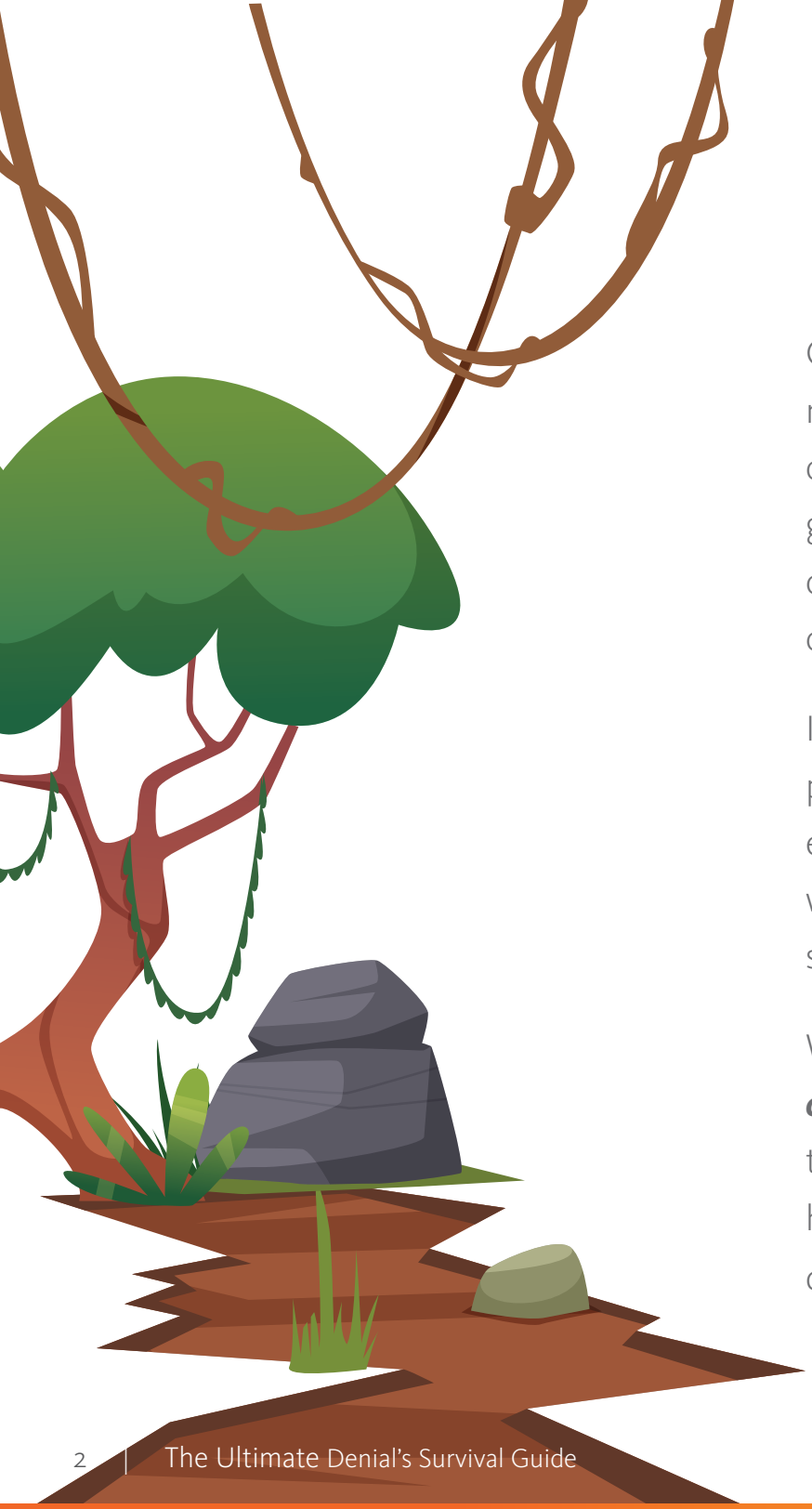
Availity®

The Ultimate Denials Survival Guide

How to avoid the pitfalls associated with denied claims

Table of Contents



Executive Summary

Claim denials are a persistent foe, steadily chipping away at staff morale, as well as your organization's bottom line. To avoid the consequences associated with denied claims, we created a "survival guide" that explores the challenges that can arise within the revenue cycle, with Availity serving as a knowledgeable guide to help your organization navigate the denials management journey.

In this eBook, we spotlight the role AI-assisted predictive editing plays in preventing denials and the impact it has on the overall efficiency and accuracy of the claims management process, and why ***it's imperative for payers and providers to work together*** to streamline the denials management process.

We also take a deep dive into the ways in which ***artificial intelligence continues to revolutionize the healthcare industry***. We will explore the technology driving improvements to data collection and analysis, and how new efficiencies and insight are allowing for more strategic, data-driven decision making and processes throughout the revenue cycle.

Know thy Enemy

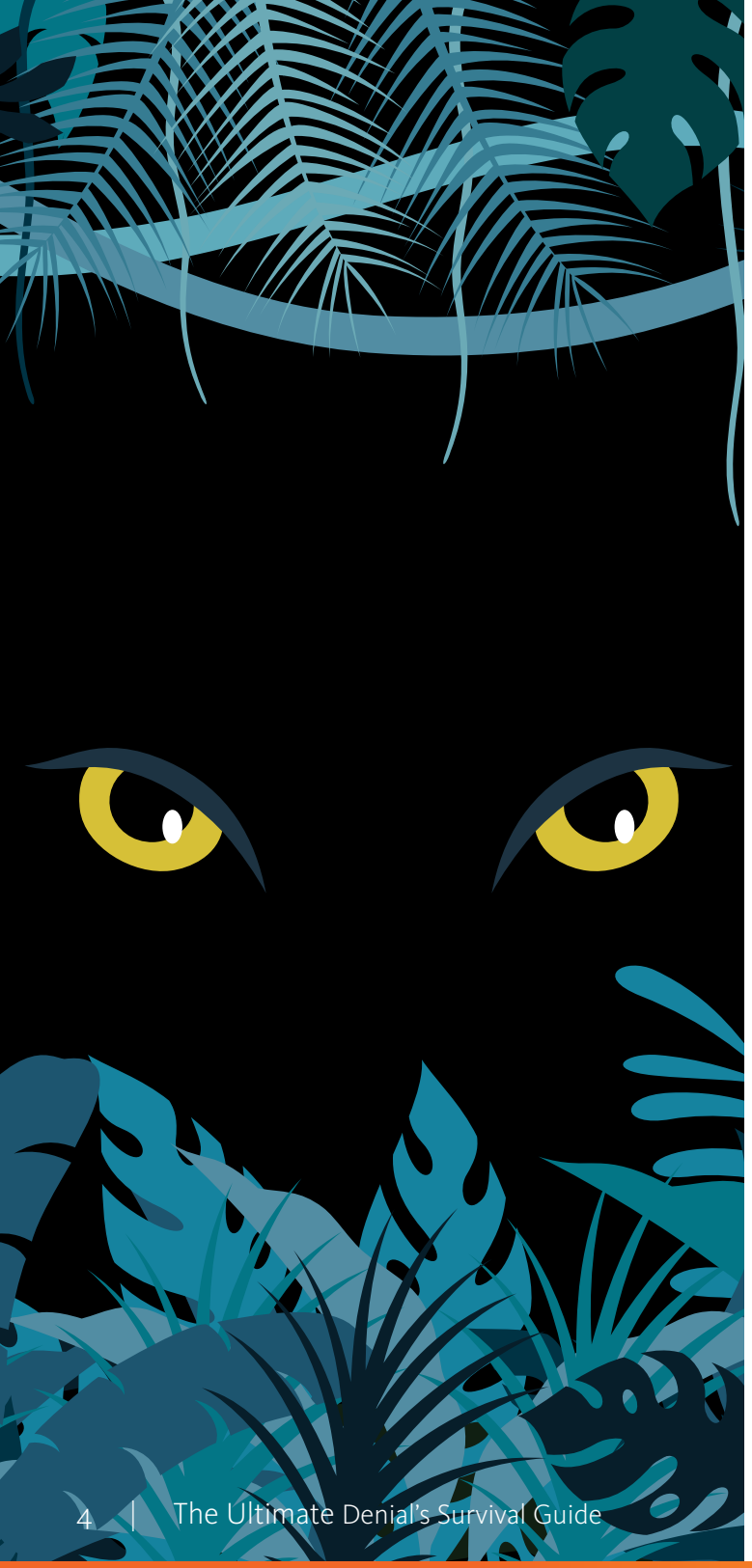
Unmasking Denials

It's a jungle out there. Challenges pop up throughout the revenue cycle journey, with denials causing one of the most distressing, and potentially harmful, risks. Denied claims not only require time and labor commitments in the form of appeals but aim in a dangerous direction down the path to increased administrative resources, lost revenue and poor patient experiences. And a flash flood of denials is on the horizon. A 2023 survey polling chief financial officers and revenue cycle leaders at hospitals and health systems throughout the United States found that nearly half of providers witnessed an overall increase in denials compared to the previous year.[1]

The claim denial rate industry standard is typically benchmarked at 5-10 percent. A rate exceeding 10 percent puts an organization in the danger zone, and when denials are high, the potential impact to revenue is significant. Denials danger may be lurking right around the corner, so provider practices and hospitals and health systems need to know what to watch out for to avoid catastrophic situations. Let's dive into the cause of these denials and analyze why they are so dangerous.

DID YOU KNOW?

The American Medical Association (AMA) estimates that claims processing inefficiencies cost healthcare organizations up to **$210 billion** a year.[2]



Common Predators

The Top Reasons for Denials

There are dozens of reasons a claim can be denied. Everything from missing documentation to concern regarding the medical necessity of a procedure can raise a red flag on the payer side.

Common reasons for denials:

- **Duplicate claims**
- **Coordination of benefits (COB)**
- **Medical documentation**
- **Timely filing**
- **Authorizations and referrals**

When it comes to completing claims, peril most often comes in the form of incomplete or inaccurate information and simple human error. Thankfully, these are easy fixes and the majority of claim denials are avoidable.

Predictive Editing: New Protection in the Fight Against Denials

Providers and payers are allies in the claims processing lifecycle, with similar goals around the claims lifecycle, and ultimately, patient care. Just as open internal communication is a necessity within a provider organization, it's also imperative for payers and providers to work together to streamline the denials management process. It's common for policies and procedures to change throughout the year, so providers must aim to stay up-to-date by monitoring updates and communicating with payers. Achieving effective communication with all parties involved is crucial for the adoption of best practices.

With health plans responsible for the rules and regulations that power the claim approval process, those on the other end often find themselves on rocky terrain. Health plans often possess varying guidelines and requirements, which then also vary by plan, state, or more. Even experienced billers and RCM experts can be blindsided by new regulations or changing payer requirements. Tacking these challenges can be even trickier if it's unfamiliar territory. A staff member may be an expert in dealing with an elderly patient population that utilize Medicare and its policies, but may have had little experience with the rules of employer-sponsored plans. Responsibility lies with leadership to ensure that those on the front lines possess the right skills through training and upskilling.

Building Your Defenses

Proper Claim Preparation

Best way to survive an emergency situation is to avoid it. But how exactly is that done?

When it comes to completing claims, danger lurks around every corner in the form of incomplete or inaccurate information and simple human error. The best way to prevent these risks is to proactively aim to avoid them in the beginning stages of the claims processing journey. Let's look at building your defenses:

1st line of defense: Pre-service eligibility verification
Inaccurate coverage information is one of the most common, but thankfully, most avoidable, missteps. Checking eligibility verification should be one of the initial steps taken during pre-service to avoid denial issues down the line. If your practice does not have adequate pre-service tools in place like eligibility verification, it's time to sharpen your tools.

2nd line of defense: Coding and documentation optimization
Any coding or billing team should be equipped with the knowledge and solutions necessary to optimize coding and prevent issues relating to common coding errors or documentation requirements. Staying one step ahead of the required needs can help fortify your defense against denials.

3rd line of defense: Meeting payer requirements
Another "sneak attack" that can cause a surprise denial comes from the payer side. Health plan requirements are known to change unexpectedly, causing processing lags and delayed payment. Completion of required fields and additional payer requirements is critical. When in doubt, communication and fast action is the best bet.

Ensuring that these pre-submission elements are complete can help your clean claim rate remain at a healthy level. By preemptively "striking down" these common threats, stressors that can complicate and delay the process are prevented on the front end.

It takes **$25** and up to

71 MINUTES

to work a denial[3]

Navigating the Jungle

How to Manage the Denial Process

Danger! Your denials have been steadily increasing over the last quarter and action needs to be taken immediately. Leadership is expressing concern. You feel like you're in quicksand and need to be thrown a rope. Hopefully this emergency scenario doesn't happen to you, but if you find yourself under a mound of mounting denials, there is a way to get out of the figurative hole.

Spotting the traps: Claim tracking and identification of denial warnings

The best question to ask when assessing denials is "Why are these denials occurring?" Determining common causes and getting to the root of the problem can provide actionable insight that will help reduce existing denials and prevent them from occurring in the future. But this is easier said than done. RCM specialists can often feel like they are lost in a jungle, without the resources needed to escape. An established denials management program can help to establish workflows, address a way to track and analyze claim data, and further define the plan of attack against denials. The analysis of existing denials can highlight areas that need improvement, and also makes trends and opportunities visible to help avoid future denials with the correct course of action.

SURVIVAL TIP

Create a denials prevention flow

- Identify your organization's top denial categories.
- Focus on root causes of those denials.
- Implement options to address those causes.

Best practices to *attack* appeals

When a denial occurs, what is the best way to tackle it? Step one is to address the threat head on. Far too often, providers ignore the denied claims that lurk in the darkness. Perhaps they lack the resources to commit time and effort to the appeal process, or assume that writing-off the claim is a simpler route to take. But taking this approach can only worsen the issue.

To begin to assess the situation, the right technology and solutions must be in place. Analytics can be used to take a deep dive into the metrics, hopefully uncovering patterns and details that can lead to the larger issue at hand. Digging a trench into real-time data allows analysts to discover the root cause of denials. From there, appeals can be filed, which must be done in a timely manner to ensure the quickest results. The bottom line? **Providers must be aggressive in their response to denials.**

50–65%
of denied claims are never resubmitted[3]

What to do in a denials emergency

1. Address the threat quickly
2. Ensure solutions are in place
3. Analyze to find the root cause
4. File appeal

Forming a tribe

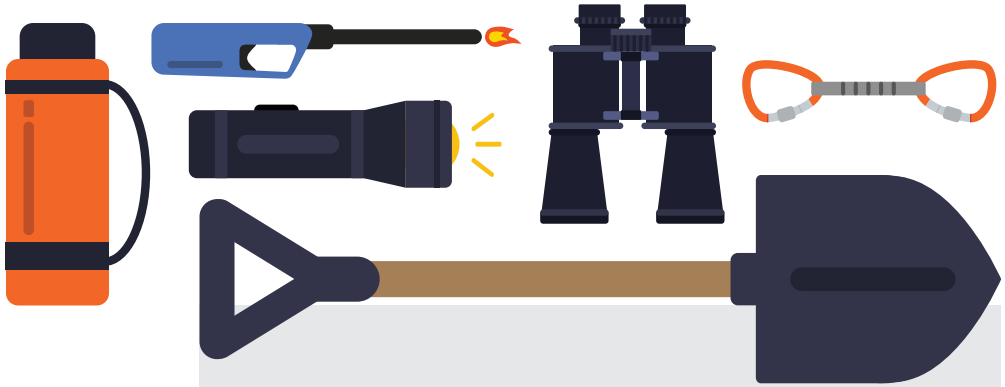
Collaboration among providers, coders and billing

Things can get wild when resources are scarce, dollars are at risk, and the quest for proper reimbursement seems like a never-ending challenge. All too often, various departments of a provider-focused organization exist in silos. When this happens, problems arise due to miscommunication or lack of information.

The situation seems a little easier to conquer when you consider that all individuals are working toward a common goal (which is quick, accurate claim reimbursement). To rise to the challenge, collaboration is the best tactic. Denials management requires a team effort, with everyone working together to reach a common goal. As the saying goes, there is strength in numbers, and collaboration also goes a long way. When stakeholders within the provider side of the process – physicians, coders and billers – communicate and collaborate, efficiencies are created, mistakes are avoided and denials decrease.

Survival Essentials

The tools you need to thrive



Conquering the challenges associated with denials requires the right tools. In the same way that one would hope to find various survival tools if lost in the jungle, your organization also can benefit from the proper resources.

Technology to the rescue

Think of technology as a key benefit in the fight against denials. Thankfully, today's ever-evolving technologies are changing the way revenue cycles are managed, proving to offer significant time and cost savings. Every provider-based healthcare organization should have a set of robust denial management tools in place. A "survival kit" should include vendors and programs that use automation to create faster workflows and improve accuracy. Eliminating manual work with automated tools that check a patient's eligibility and benefits allows for easy discovery of coverage, co-pays, deductibles, and co-insurance. Using technology to climb the mountain of mandatory tasks like insurance verification not only saves time at the time of service, but can also can help to avoid any coverage-related denials that may arise. Other tools that assist with coding and documentation are also valuable when "in the trenches" of the claim submission process.

With tools that bundle many features such as Availity's Essentials Pro™, it's easy to monitor and measure key actions and metrics relating to denials. Availity Essentials Pro is a premium, all-payer clearinghouse empowering some of the nation's largest hospitals and health systems with revenue cycle automation, AI, and expert client consultation. A team of revenue cycle experts and Client Success Managers have deep experience helping providers across the country achieve their business objectives and optimize their systems to get paid faster and more accurately.

An estimated

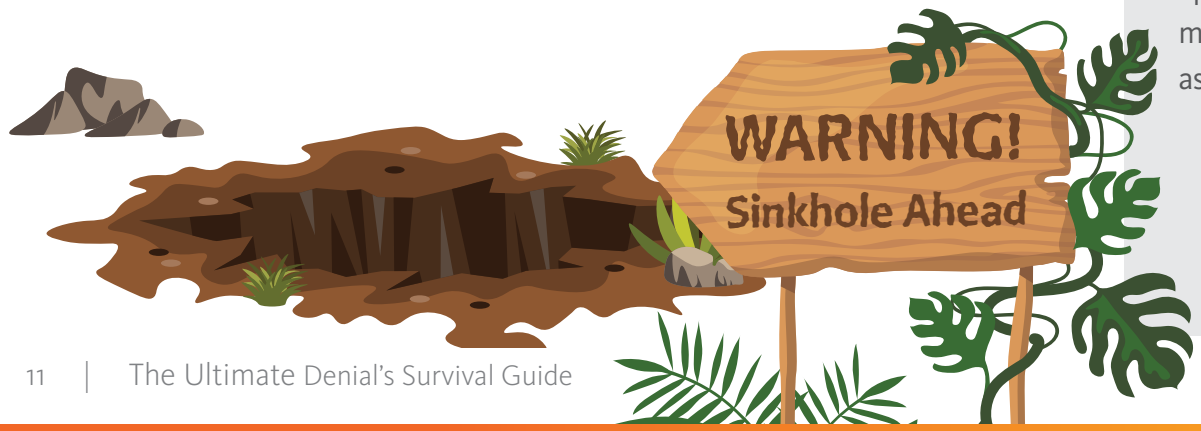
80–90%

of denials are avoidable with the right processes and tools.

Predictive Editing: New Protection in the Fight Against Denials

Along with tools that prevent eligibility emergencies, preventive editing functionality can greatly benefit denial prevention strategies in the pre-submission stages. Utilizing custom-built artificial intelligence algorithms based on analysis of millions of claims, Availity's Predictive Editing tool proactively identifies potential denials dangers. Using advanced AI, Availity's Predictive Editing tool identifies and flags select claims for review, allowing providers to take action to remedy any issues prior to submission. Because claims are corrected at the beginning of the claims workflow, significant time and resources are spared.

Predicting which claims are most likely to be denied can help ensure that claims are submitted correctly the first time. By adding Predictive Editing functionality to the Availity Essentials Pro solution, providers gain a robust claims editing suite of tools to effectively manage the revenue cycle.



How Availity Can Help Neutralize Threats

When denials danger strikes, will your organization be adequately prepared? One of the most important items a business can possess in their RCM toolkit is a vendor that is familiar with navigating the claims lifecycle jungle. Having a partner in prevention goes a long way when trying to conquer denials, with vendors bringing years of expertise, collaborative communication and new functionality and ideas for process improvements.

Availity's Essentials Pro, coupled with our vast network of RCM experts and payer connections, facilitates a proactive approach to denials management and revenue cycle management that help you remain vigilant amidst the risks associated with the treacherous landscape of denials.

For more survival tactics:

Visit Our Site

References

[1] Ray, Jasmyne. “An Inefficient Front End Could Be Denying Revenue Cycle Leaders Cash.” Health Leaders, Oct. 19,.2023, https://www.healthleadersmedia.com/revenue-cycle/inefficient-front-end-could-be-denying-revenue-cycle-leaders-cash

[2] Reiner, Glen. “Success in Proactive Denials Management and Prevention.” HFMA, 16 Dec. 2022, https://www.hfma.org/revenue-cycle/denials-management/61778/#footnotes

[3] MGMA Resources: You might be losing thousands of dollars per month in ‘unclean’ claims, 2014. https://www.mgma.com/articles/you-might-be-losing-thousands-of-dollars-per-month-in-unclean-claims; MGMA Resources, 4 keys to driving down denials, 2018. https://www.mgma.com/resources/revenue-cycle/4-keys-to-driving-down-denials; JAMA, Waste in the US Health Care System: Estimated Costs and Potential for Savings, 2019. https://pubmed.ncbi.nlm.nih.gov/31589283/

About Availity

Availity is the place where healthcare finds the answers needed to shift focus back to patient care. We work to solve communication challenges in healthcare by creating a richer, more transparent exchange of information among health plans, providers, and technology partners. As one of the nation’s largest health information networks, Availity facilitates billions of clinical, administrative, and financial transactions annually. Our suite of dynamic products, built on a powerful, intelligent platform, enables real-time collaboration for success in a competitive, value-based care environment.

Availity®