As hospitals, health systems, and independent practices strive to overcome critical staffing shortages and push towards an increased focus on patient experiences, they need more efficient and effective processes and policies to maintain financial health. Stopping medical claim denials before they have a chance to occur is the best way to ensure hospitals and providers receive correct payment quickly and efficiently.

In this eBook, you’ll discover two crucial KPIs that can help stop denials from happening on the front-end of your revenue cycle rather than the back end to increase clean claim rates and reduce immediate denials. We also look at the top-five most common types of medical claim denials and share a Q&A on strategies to help improve denial management from Lori Brocato, Vice President, Product Management at The SSI Group, LLC.

What’s Inside?

- Two Crucial KPIs You & Your Organization Need to Watch
- The Top-Five Most Common Types of Medical Claim Denials
- Q&A with SSI Revenue Cycle Expert: Lori Brocato, VP, Product Management
Two Crucial KPIs to Watch

Two Crucial KPIs You & Your Organization Need to Watch

Stopping denials from happening on the front end of your revenue cycle is a much better strategy than managing denials on the back end.

With an industry average denial rate of 5-10% and a clean claim rate of 90%, SSI’s insights on these types of denials and denial prevention strategies can help you improve.

90% Clean Claim Rate (CCR)
A foundational understanding of CCR is essential. HFMA defines a CCR as “a trending indicator of claims data as it impacts revenue cycle performance.” Meaning – the number of claims which required no manual intervention or touches.

For example, when an SSI client processes a claim, the claim is programmatically run through a claim scrubber, which automatically applies the appropriate edits and then sends the claim off to the insurance carrier via a clearinghouse. In this case, no person interacted with the claim after the edits were applied. However, some organizations have adopted their own rules for claims processing, which require someone to edit or change claims for reasons specific to them. Bear in mind that touches equal time and time equals money.

Any manual intervention can slow down claim processing and delay payment. In either case, adopting a CCR target of ninety percent seems to be the latest trend across provider organizations. SSI recommends using this as a benchmark to determine whether or not additional work is required.

5% Initial Denial Rate (IDR)
At the back end of your revenue cycle, it’s vital to keep an eye on the IDR. Your IDR is the percentage of claims denied at the first initial response from the payer. This rate is calculated by taking the total initial denied claims and dividing that number by the total number of claims submitted. That can get a little tricky in terms of what you should or should not include in those numbers.
For example, most organizations exclude rebills from these totals, but others do not. For SSI clients, we recommend excluding rebills when calculating your IDR. Again, confirm what is and is not included. For reference, SSI recommends a five to ten percent IDR benchmark, with five percent being the ideal target.

Monitoring your organization’s IDR by the payer is also vital. For example, if you run your IDR calculations by your highest volume payers, you may be able to quickly identify those that are having the most significant impact on your IDR. From there, you can appropriately focus your resources to make improvements on the claims going to those specific payers. And keep a close eye on any positive correlation between your IDR and CCR. For example, what you don’t want is for your CCR to improve, and as a result, your IDR increases.

When comparing your organization’s CCR and IDR rates to other organizations, be sure to compare against those of like type (size, location, specialty, etc.).

When comparing your organization’s CCR and IDR rates to others’, match up like types – size, location, specialty, etc.
Eligibility-related denials often result in a hard denial or one where you will not likely be paid. These include denials related to:

- Coordination of Benefits
- Plan Coverage
- Incorrect Plan Code Entry
- Maximum Benefit Exceeded
- Inactive Coverage
- Member Not Found

Eligibility-related denials often stem from either the information not being obtained from the patient during preregistration or when they present at registration. These denials can even come from the fact that coverage changes during the patient’s hospital stay, especially if you have a patient whose hospital stay spans months on end. The most effective way to prevent these types of denials is to gather the correct information from the patient upfront. Still, even this won’t prevent all eligibility denials.

Another option is running eligibility checking before billing the claim, combined with utilizing a coverage discovery tool that will seek out active coverage on a patient. Ultimately, eligibility-related denials are worth the effort to deploy all your available strategies to prevent or lessen their occurrence.

Missing or invalid claims data denials are generally considered soft denials. A soft denial means you can usually fix the claim and resubmit it for payment. These types of denials occur when the data submitted does not pass the payer’s adjudication edits – a clear sign that key data may be missing. If you’re billing secondary claims, it could also suggest invalid or missing data in the remittance advice information submitted on that claim.

In most cases, missing or invalid claims data denials can be prevented with a robust edits library as part of your billing or claims management software to prevent claims from being submitted with missing or invalid data. Alternatively, you may be able to utilize your host system, such as those included as part of your EHR software, to manage and correct potential missing or invalid data, so there’s no additional intervention required before the claim is submitted. These types of claims-related denials are important to resource appropriately to avoid hard denials and thereby loss of revenue for the organization.
3 | Authorization-Related Denials
Authorization-related denials typically end up being hard denials. You can’t fix hard denials, nor can you recover any payment on these claims. These denials surface when a provider didn’t obtain a required authorization before service or included an invalid authorization number on the claim.

Sometimes a claim will be denied despite prior authorization. These denials often result from eligibility issues such as a change or expiration of patient coverage after receiving authorization but before using it. Payers also often have time limits and expiration dates associated with authorization numbers and, if not used within their specified time frame, will also receive a denial.

In cases where you receive notice of services exceeding authorization, you may be able to appeal these claims and recover the denied amount. However, for these denials, it is highly dependent upon having the appropriate documentation as to why the services exceeded authorization and proving why the provided services were necessary.

4 | Non-Covered Service Denials
Non-covered service denials are almost always hard denials. It’s unlikely you’ll be able to recover any dollars associated with these claims. When these types of denials occur, it’s often because the payer’s plan did not cover the provided service. You can also get this type of denial when a patient’s stay goes over the maximum number of allowed days for a particular service. In addition, a non-covered service denial could also be associated with restrictions on a managed care plan that were not adhered to. Although you may be able to provide documentation via an appeal for these types of claims, more often than not, these claims will not be able to be recovered.

5 | Missing Documentation Denials
Missing documentation denials are generally soft denials, and you will likely be able to fix what’s missing and resubmit the claim. Just as the description states, these types of denials are missing documentation. Either the requested documentation was not provided initially or was provided but not received. These cases are also often referred to as technical denials. Sometimes the documentation was not provided in the payer’s required timeframe. In other cases, claims denied result from receiving inadequate or insufficient information. It’s possible to appeal these claims by resubmitting additional details as the payer needs.

Another type of missing documentation denial is one where documentation provided does not substantiate the service. You still might be able to appeal these claims if you can provide the documentation to prove the service was necessary and why. In all cases of missing documentation denials, if you plan to try and fix what’s missing, you must promptly provide any necessary additional documentation per each payer’s guidelines. Having a solid clinical documentation improvement (CDI) system will also help you prevent these types of denials.
Q&A with SSI Revenue Cycle Expert: Lori Brocato, Vice President, Product Management
Key strategies to make improvements in denial management

What are some quick-win strategies to improve CCR and IDR?
Lori Brocato, Vice President, Product Management: I’d be remiss if I didn’t spend some time talking about edits here.

1. Keep an eye on your edit trends and look for changes month over month to determine your edits’ effect on both your CCR and IDR.

2. Second, it’s a good idea to look for edits that are no longer applicable and turn them off.

3. If you have any “catch-all” edits in place, take a look at those and see if it’s possible to break them down further and make them more specific. These first three steps alone should equal a more efficient use of edits on the front end, which typically helps improve claims management down the line.

4. Look for bypassed edits and understand the reasons for these to determine if you can make any significant or subtle changes to these edits that might have a big impact downstream.

5. Even if your organization doesn’t have a lot of resources to put toward monitoring and managing your edits, you may find that setting aside a small amount of time weekly or monthly to review and tweak here and there can deliver big results.

Can you share any quick-win strategies when it comes to specific types of denials?
Lori Brocato: Sure. The first one that comes to mind is timely filing denials – sometimes called never denials. Maybe not the most common type of denial, but we often find ignoring these types of denials still equals money left on the table. And for those that are recoverable, it could be a simple, easy fix. I suggest starting with those payers that are the main drivers behind these types of denials and then focusing on those that represent the highest dollar amounts (true for all types of denials). Take a look at specific claims, codes, dates, and more to try and uncover the how, what, and if you can make changes that would help you avoid these types of denials. I also recommend you schedule weekly reports utilizing your billing or reporting system that will help you identify claims that are nearing the timely filing deadline and be sure to include the payer as a filtering field.
The second type of denials that comes to mind is eligibility-related denials, which happen to fall within the five most common denials. Applying strategies to address upstream issues helps reduce these denials on the back end. Take full advantage of your billing vendor’s edits, and at the time of billing, re-verify eligibility to ensure coverage is still active, correct payer, etc. As we all know, eligibility information can change from the time you first collected it. This extra step alone can save significant time and money on the back end.

Any denial you can correct & resubmit quickly – **those are quick wins in my book.**

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**What advice would you give those seeking help prioritizing working their denials?**

Lori Brocato: As I mentioned earlier, the low-hanging fruits are denials that you can quickly correct and resubmit. So, that’s a good starting point. From there, I’d take a look at prioritizing repetitive denials that might have a simple fix.

Is there something these denials have in common that you could fix by implementing a change in your host electronic health record system or that might be able to be automatically plugged in during the download of claims into your billing vendor’s system? These are things that could fix a lot of errored claims and claims that get denied for the same reason.

I also recommend using your system’s flags, edits, reminders, etc., to address issues, especially those around timely filing. Most systems do provide these types of notifications that can let you know when you’re reaching a timely filing limit, and I highly recommend people take advantage of those notices.

Another option is to **workflow your denials.**

There’s technology out there, including what we offer here at the SSI Group, allowing you to automatically assign denials to a resource that can best address them. Organizations assign denials to root cause owners based on the denial. It makes sure the best person in that area of expertise is the one who addresses it. This process also helps educate users by showing what errors are occurring and empowering them to implement strategies to help prevent those specific errors from recurring. Technology also allows you to prioritize high-dollar denials above lower-dollar ones, especially high-dollar denials that may have quick fixes. You can even use different workflows to address appeals specifically and prioritize them based on the level of complexity and determine who is best to handle each type.

Ultimately, everyone works denials a little bit differently and needs to find what works best for you and your organization. Some organizations use the same staff to handle billing and denials. Others separate these functions from those focused on follow-up only (rejections, denials, and appeals). And some send denials back to the department or area responsible for the denial. And in some cases, organizations completely outsource their denials.
**Are there any specific recommended strategies around reprocessing claims and filing appeals?**

Lori Brocato: I think it’s imperative to use electronic submissions for reprocessing claims and, in some cases, even filing appeals, which gets the claims there faster. And you want to be sure to follow payer-specific guidelines for claims resubmission. For example, some payers require you to submit a corrected claim with the XX6/XX7 bill type, while others don’t care – meaning you can correct the original claim and rebill it. Knowing these guidelines is essential because if you don’t follow them, you will end up with another subsequent denial.

A lot more payers have started offering the ability to file appeals online, or they’re at least allowing you to start the process with online forms. In addition, Medicare recently rolled out their Electronic Medical Documentation Requests (eMDR) process where they are electronically sending out requests for medical documentation for their Recovery Audit Contractor (RAC) audits and other types of audits. They are getting closer to having a fully electronic process, and I see a lot of other payers moving in this direction.

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**Do you have any tips for tracking and monitoring new denials?**

Lori Brocato: A monitoring or tracking system that helps catch new denials is beneficial. You don’t want denials to become commonplace, so catching them quickly is key. In the absence of a technology vendor, you will want to be sure you can keep up with new payer requirements, read your provider bulletins that you get from your payers, check payer websites, etc., but hopefully, you’re working with a technology partner who does all of this for you.

However, if you’re working with a technology partner and a new denial does show up, I’d first ask myself, “Is this a new payer requirement, and is this something I need to get an edit put in place for?” Next, I’d want to know, “Did my organization just sign a new contract with a payer, and is it possible there’s something new in the contract that we should be accounting for?”

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**How do risk-based agreements affect denial management and appeals?**

Lori Brocato: When it comes to managing claims and denials associated with risk-based agreements, it’s vital to work closely with your clinical team to make sure claims are coded accurately because you can have monies tied up in these claims for treating sickler patients. Organizations want to document those patients for continuously treated conditions.

In some cases, it just won’t be worth appealing the claim. For example, maybe you don’t have the documentation to support a service, or if the documentation is vague, it might not be worth it to appeal it. Of course, take the dollar amount of the claim into consideration, as well as your relationship with that payer. Maybe even go back to the payer and let them know that you are working on educating your physician and clinician teams to make sure they are documenting more appropriately and meeting documentation guidelines in the future.
Do you have any final thoughts around denial prevention?

Lori Brocato: I’ve read that around ninety percent of denials are preventable. So, if that’s the case, I’d say every organization can make improvements. Here are some additional examples to consider. Are there edits firing on claims that still result in a denial for the same reason? Is it possible those edits are being bypassed? Duplicate claim and payment denial reason is one example. You then have to ask yourself, is there an opportunity for those to be prevented by a change in process on the front end. You always want to be working smarter, not harder. This is an example of something that could be addressed on the front end but not on the back end.

Remember, you can’t manage what you aren’t measuring, including KPIs, edits, denials, and rejections. These are key factors in your revenue cycle performance and need to be measured and monitored. Software tools help you significantly in this area and allow you to dig deeper and deeper until you find those root causes.