

November 2017

**Practice Management Tips and Tools – Denial Management 101**

Sometimes to be effective in the financial management of your Anesthesiology and/or Pain Medicine practice, you have to begin at the end – by analyzing and working your claim denials. This Timely Topic provides suggestions on analyzing your denials and improving your total denial rate.

**Calculate the Denial Rate**

The first step in denial management is calculating and tracking your denial rate. Some practice management software will provide this key performance indicator (KPI) for you. However, it is important to know how the KPI has been calculated and for what specific time period. Some practices use the total dollar amount of claims denied divided by total claim dollars. Others use total dollar amount of claim lines denied divided by total claim dollars, which may be more effective in identifying actual denials. For example, if there are five claim lines but only one line denied, tracking denials by claim lines may be more accurate than tracking by the claim. Another element to consider in your calculation is whether your rate includes first-time processing only or all denials, including all take-backs or recoupments that may have resulted from payer or Recovery Audit Contractor (RAC) audits. If determined by your software, the denial rate is typically affected by how your claims payment posting and adjustments are applied in the system. For example, if your payment posting is only applied at the claim level instead of the claim line level you may not have the most accurate KPI.

Measuring your practice's KPI against national denial rates can help determine the effectiveness of your revenue cycle management processes. According to Medical Group Management Association's 2017 MGMA DataDive Practice Operations (based on 2016 data)<sup>1</sup>, top performers have denial rates of 1% or less of their first submission claims. The national median denial rate is 3%. At the 75<sup>th</sup> percentile the first pass denial rate was 10%. These rates are for reporting by surgical single specialty practices, which included anesthesiology and pain medicine practices. If the denial rate for your practice is greater than 3% that might indicate significant opportunity for revenue enhancement and/or process improvement.

It can also be helpful to review your denial rate by payer, location or provider to target specific problem areas. For example, your practice denial rate might be 4% in the

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<sup>1</sup> Medical Group Management Association, 104 Inverness Terrace East Englewood, Colorado 80112. 877.275.6462. [www.mgma.org](http://www.mgma.org) ©2017.

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aggregate, but 15% for Provider X, or Location Y might indicate a credentialing issue with 100% of claims for Payer Z being denied for this provider or location.

#### **Identify Top Denial Reasons**

The next step is to identify your top denials. Payers associate Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) with each claim line processed. The CARCs and RARCs combine to identify why a claim line processed the way it did, including whether it paid fully according to your provider contract with the payer and why a particular adjustment may have been applied. You may read more about the specifics of CARCs and RARCs in the previous Timely Topic [EOBeware!](#) Filtering and prioritizing your denials by CARC will help to identify specific processes and data elements that may be causing the greatest potential revenue loss to your practice.

Denials can typically be broken down into specific categories, for example:

- Credentialing (See our Timely Topic “[Got Credentialing?](#)” from earlier this year)
- Registration/demographics
- Preauthorizations
- Charge Entry
- Claims Coding (including [Medical Necessity](#))
- Benefits/Coverage
- Additional Information needed
- Timely Filing

Once you have analyzed and prioritized your denials by the revenue impacted, you can customize your own practice denial categories. Tracking the denial categories based on specific practice processes can help you take the next step in denial management.

#### **Work the Denials**

Many types of claim errors can be corrected and the claim resubmitted for possible payment. It is important to be timely when working your denials and to work within each payer’s claim resubmission requirements. Delays or deviation from the payer’s requirements may cost you the payment of your claims. This cost is in addition to the cost in time and resources required for working the denials.

Do you have a process on how to work each type of denial? Establishing such processes can help both with working the denials in a more timely fashion as well as proactively reducing future denials. As an example, the coding denials process might include these actions:

- Review the charge sheet to make sure the right codes were billed
- Review documentation to validate the codes billed
- Identify the need for appropriate modifiers to be appended

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- Confirm services with the rendering provider
- Confirm [Medical Necessity](#) and coverage requirements with the payer's policy
- Follow payer policy for submitting a corrected claim or appeal if applicable

Some practices will assign the claim error corrections to those responsible for causing the error. For example, the correction of demographic or insurance information might be assigned to the registrar and coding errors might be assigned to the coder. Other practices will have the billers correct the claims in order to expedite the work. Regardless of who makes the corrections, tracking errors by department or user provides opportunities for improvement and to reduce future claim denials.

#### **Educate**

Once you have identified, tracked and potentially corrected the claims errors, it is important to educate your team and providers on the issues causing the denials. Each denial disrupts your revenue flow. Proactively work to decrease avoidable denials by continuing to track and educate on processes causing these denials. Consider revamping front-end or clinical processes that might be causing the denials.

For those who have outsourced billing, some of these steps may overlap with responsibilities at the billing company. In any case, you may want the billing company to provide you a denial analysis with top denials and the denial rate. In addition, the billing company could provide education and process improvement recommendations to assist with the reduction in denials. Consistent communication between the billing company and the practice, along with clear expectations of which party is responsible for specific steps in the revenue cycle management processes are essential in reducing your denials and improving your revenue flow.

It is unlikely that you will completely eliminate all denials. However, by following these steps you may reduce the highest volumes of avoidable denials, improve cash flow and increase available time to work on alternative concerns. Knowing how to analyze and reduce denials is an important tool in the anesthesiology practice manager's toolkit.