

# Inside Perspective

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## Denials Management Key Performance Indicators—Do you know what your top denials are?

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The CFO just called. She wants to know, “Why did our Medicare cash collections drop last month? Can you tell me why we didn’t collect as much? I need to report to the board tomorrow.”

As the adrenaline courses through your body, you resist the urge to blurt out, “I don’t know.” So you pause for an uncomfortable moment, catch your breath, and calmly say, “Let me do some research and get back to you on that.”

Lunch can wait. You drop what you’re doing and frantically check with your Patient Financial Services (PFS) department and billing staff. You start running reports, checking systems, and embark—probably not for the first time—on the quest to discover “What’s the problem with Medicare?”

Sound familiar? Wouldn’t it be nice to say, “Sure, I have that information; it’s in our Denial KPI Indicator Report.”

For PFS departments, denials can be a dirty word. It’s always something—the diagnosis code you submitted doesn’t meet medical necessity; the insurance company didn’t authorize the CT scan; the patient didn’t have coverage at the time of service. So many denials, so little time. Managing them is a full time job, and quantifying them can be a daunting process.

Here are some tips for organizing your processes and implementing your MEDITECH system to simplify denials reporting and trend them to the revenue cycle.

### Step One. Classify Your Denials: True versus technical denial logic

There are technical denials—you know, the ones where you resubmit the claim with corrected data and think that you should get paid. And then there are true denials—the claims that get rejected for no coverage at time of service or deductible. These are the ones the insurance carrier won’t pay and you hope the patient will. PFS management wants to make sure someone processes them promptly, and the CFO wants to know if and when they’ll eventually get paid.

With the standardization of ANSI reason codes, the reporting of denials has become a lot less burdensome, even if you don’t process your payments with an 835 4010 remittance file. It’s a good idea to analyze your ANSI reason codes and/or local carrier denial reason codes and subcategorize them. This helps in a couple of ways:

- It groups denials into sub categories such as eligibility, precertification/authorizations, coding, deductibles and co-pays.
- Within those sub categories, it lets you establish which denials your billing department can and will process.

Your organization’s billing practices can be used to determine which denials in these categories are “true” and which are “technical.” This serves as a baseline for expected reimbursement because you have quantified which claims you can reasonably expect to be reimbursed for and which ones you can’t. It also helps you to diagnosis systemic issues in your revenue cycle.

### **Step Two. Quantifying the data: Who, what, where, why, and how many**

There are several reasons why KPI reporting sometimes fails. Data is not clearly defined, or it may take several reports to capture all the elements. Or it simply takes too long to summarize the data. That's why simpler is always better, especially if this is all a little new to the organization. You'll want to define your data elements based on your denial logic criteria; you'll also need a good grasp of the denial management processes—so enlist the help of your IT, PFS, and Finance departments.

While most of the data elements can be obtained through B/AR selection reports, NPR reports are usually the preferred method, because they can access several different modules and DPM's to capture data that may not be easily obtained through B/AR or B/AR standard reports. Data streams your finance department might want to incorporate are insurance mnemonic, remittance code, ordering physician, location, and/or account type. Try to keep these reports as succinct and easily verifiable as possible, because most likely they will be downloaded into Excel or other databases and sorted by the finance folks. Developing lots of reports that don't contain the same data and can't be tied back and balanced by your Finance department is a recipe for disaster.

### **Step Three. Trending the Data: Developing your benchmarks**

It's not enough just to capture data; you have to develop specific performance metrics to make sense of it. One way to trend your denials data is to report denials as a percentage of monthly net or gross revenue.

Establish a performance metric based on this percentage. For example, Medicare medical necessity denials are less than 10% of net revenue per service line. But you can't develop these metrics by yourself; it takes a village. Put together a multi-discipline revenue cycle committee and enlist them in the process of KPI development. This establishes organizational accountability as well as buy-in. Be sure to incorporate your metrics in your facility's strategic plan, departmental goals and objectives, and performance evaluations. When every department becomes a stakeholder in the revenue cycle process, your organization will trend towards improved cash flow, streamlined processes, and better trained staff.

And the next time your CFO calls and asks "Where's my cash?" you can "show her the money" with your KPI Indicator Report!

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