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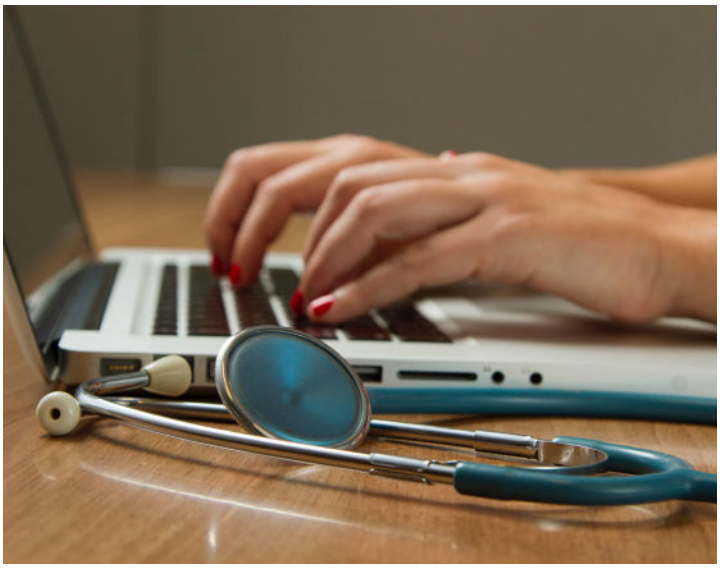
Routine Denials

Routine denials are a point of frustration for many practices, especially when they appear to happen automatically. In most cases, providers recommend services, procedures, medications, and medical equipment because they feel it is in the patient's best interest. Yet so many submitted requests are denied. In fact, Healthcare Finance News reported, "13% of Medicare Advantage enrollees had a claim or pre-authorization request denied" (reference 1). In addition, a significant portion have had their requests overturned upon appeal. This is similar to claims submissions in which data from Health and Human Services shows that in 2021, over 20% of denied claims were overturned upon appeal (reference 2).

This is frustrating for providers who want to do the best for their patients. In fact, in the industry, we often hear the complaint that payers are attempting to practice medicine. This has been going on for a long time as payers attempt to curb the expenses and providers attempt to get the best for their patients.



One payer I spoke with who asked to remain anonymous said, "If we overturn 99% of our denials on high-cost medications, the 1% that remain denied more than compensate for all of our administrative efforts in processing original denials and follow-up appeals". So how do we find balance?

Well, HHS has taken up that task. There were many associations who have asked for support but AHA has perhaps been the most fervent, stating that the DOJ should "establish a task force "to conduct False Claims Act investigations into commercial health insurance companies that are found to routinely deny patients access to services and deny payments to healthcare providers" (reference 3).

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In the meantime, what can providers do while this is sorted out? There are three things that can help practices:

1. **Assess your data**. With your 835s, you have the data needed to evaluate what is being denied, how often, and by whom. You also have the data needed to ascertain what is being overturned upon appeal. Dig in, take a look at what was required in order to overturn.

2. **Reach out to payer's**. Where possible, attempt to have services gold-carded, meaning you are automatically approved based on a history of prior excellence or high overturn rates upon appeal.

3. **Shake things up.** Identify frequently denied claims/services/procedure codes and change the process for submission of those claims. Can you submit records at initial submission? Are there prior authorization requirements that aren't being met during submission? Are there tried/failed activities that providers need to know about in advance?

HHS pulling in the Office of the Inspector General (OIG) is a step in the right direction, but it is certainly going to take some time before we see systemic change. Waiting for that to happen means unnecessary time being spent by your staff on appeals and redetermination processing. Taking proactive measures to prevent what you can will help to increase efficiency and help you take back control of your revenue cycle. The OIG has already done an initial evaluation in 2018, you can dig into more information here. For more information on denial management, check out our blog from March or the April session from our 2022 RCM Webinar series.

References:

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