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Preventing Denials through Teamwork, Innovation and Technology

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Prevention, the saying goes, is often the best medicine. That is certainly true for maintaining your personal health, but it is also true for organizations striving to stay financially healthy—especially when it comes to preventing denials, an increasing threat to hospital revenue streams.

In some cases, denials have risen as an unintended consequence of hospitals becoming more efficient in other areas. The following case study describes one such situation that resulted from hospitals' success in reducing length of stay, and details the process and tools used to reduce denials.

The Downside of Shorter Length of Stay

In recent years, hospitals have made great strides in reducing length of stay by becoming more effective at providing the right care at the right time. One result of shorter inpatient stays, however, is less time to complete the notification and authorization of clinical services required by payers. When the stay was short, often times the notification and authorization process could not be completed before the patient bill was sent to the payers. As a result, the claims were denied.

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Through our analysis of more than 225 Parallon client hospitals, we could see that denial for non-authorization was one of the top three reasons claims were denied. Equally concerning, inpatient claims lacking authorization accounted for more than 24 percent of all write-off accounts.

We needed a more efficient and effective way to deal with the problem that required less time sorting through accounts and less time invested by case managers at hospitals. There was no question this was ripe for an investment in a better solution.

Pairing a Team with a Tool

Our first action was to create specialty pre-bill denial units, or PDUs, in our Revenue Cycle Shared Services Centers to enhance our existing payment compliance service. With the creation of the pre-bill denial units, we moved the task of dealing with these types of accounts from hospital case managers to the newly dedicated pre-bill team. These new PDUs are charged with following up on post-discharge, pre-bill accounts that required authorization.

With the team in place, we quickly recognized that we needed a better way to identify claims requiring authorization. We assembled a team of designers, developers, resource managers, product analysts and testers. To facilitate the process of identifying claims vulnerable to denials, the team created a software tool that searches through all claims for those that are two days post discharge and without documented authorization. The tool scrubs the system for those accounts and then sends them to an unworked queue, signaling the need for review to the work team. The review team then follows up with the account by contacting payers to identify needed codes or provide requested clinical information.

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The Outcome

For the first full year of implementation of the pre-bill denial units, client hospitals saw a 12 percent reduction from the prior year in the dollar amount of payment denials. That improvement represented a 382% return on initial investment.

Another important outcome was workflow efficiency. By automatically flagging those accounts requiring a review, the software tool frees-up more time for staff to focus on obtaining payer authorization and actually preventing denials instead of sorting through accounts. The staff is also able to work on a higher volume of accounts. Importantly, by taking this specialized task out of the hospital, we enable facility case managers to devote their time solely to patients in the hospital, not those who have already been discharged, which helps ensure better care and improved claims accuracy overall.

One final, but invaluable benefit, especially in light of the importance of patient experience: The PDU and tool reduced the number of bills sent to patients showing charges that have been unnecessarily denied.

Lessons Learned

Having gone through the entire process of identifying an opportunity for improvement, developing a strategy, and designing a solution, we realize not only the financial value of the PDU and the new tool, but also recognize better strategies for operational improvements.

We also affirm the importance of standardization. Employing common processes and language across departments and facilities improve efficiency and reduce the chance of error. One example is the use of consistent language among patient access, case management, and PDU staff when handing off patient accounts. We implemented a system in which if the payer supplies an authorization code for a clinical service upon admission that information is included in the patient account information sent to case management and the PDUs. If the status is inpatient, patient access will add a slash and the capital letter "I" to the code to denote inpatient status. The code also includes the authorized length of stay. Such readily available information prevents multiple calls to the payer from different hospital departments seeking authorization. The information also alerts case managers to any real need to contact the payer, such as to provide additional clinical information to obtain approval for an extended length of stay. Consistent language and processes enable departments to work collaboratively, rather than in silos.

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With so many variables, denials are an inevitable part of the revenue cycle process. In an era of at-risk payment and tightening reimbursement, taking steps to identify specific problems and create dedicated solutions should be a part of the strategy for provider organizations.

About the Author

Marie Hamlet, RN, *is the vice president of utilization review, revenue integrity and provider credentialing for Parallon. Marie brings more than 25 years of clinical revenue cycle experience, spanning several top-performing hospitals and systems.*