SEE YOUR REV CYCLE DIFFERENTLY

STOP THE WRITE-OFFS

7 strategies to improve cash flow

Part one: strategies to prevent denials

WAYSTAR

Denial Management

Denial management in healthcare continues to be a challenge—in part because the traditional way of working denials is time-consuming, costly and prone to error. Denials eat up as much as 3 to 5% of provider revenue, and according to some projections denial rates trend as high as 20%.[1]

In healthcare today, the goal isn't just making denial management more efficient through the right technology and operational changes. To avoid costly backlogs and lost revenue, providers need to reduce their overall denial rate and zero in on what's really driving it and where they can leverage the greatest opportunity for holistic AR improvements.

Both prevention and effective management of denials are key to profitability. Like all RCM challenges, the root causes of denials are fundamentally interconnected, so let's begin with three strategies to prevent denials. In part two of this series, we'll explore four strategies you can implement to expedite denial resolution.

Read this white paper to learn more about the problems with manual claim status inquiries—**and how to solve them.**

What's inside: Part 1

1 **Start in the front office.** The role of front-office staff in reducing the #1 cause of denials

2 **Make sure documentation lays the groundwork for success.** Bottlenecks and pitfalls in clinical documentation that can undercut efforts to reduce den

3 **Catch claims that will be denied.** Prevent denials by catching incorrect claims before they reach the payer

1 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings

1 Start in the front office

Denial management is sometimes seen as a purely back-office function. Cash flow improvement requires a different perspective. In the context of outpatient care and planned inpatient services, denial management starts before patients ever arrive for their appointment. In fact, your front office holds the keys to preventing the most frequent cause of denials, including:

- **Ineligible/uncovered services**
- **Failure to obtain prior authorization**
- **Lack of medical necessity**
- **Incomplete/inaccurate patient demographic information**
- **Service covered by another plan/payer**

90%
of denials are preventable[2]

2 out of 3
denials are recoverable[3]

Ineligibility accounts for up to **75%**
of denials & rejections[5]

Nearly all eligibility-related information can be uncovered and confirmed prior to the time of service—by leveraging effective and accurate patient eligibility verifiation technology. In addition to accuracy, eligibility verification technology will also save your staff an average of nine minutes for every transaction versus manual methods.[4] Even if the full information isn't verified before the patient arrives, it can be quickly verified or amended as part of the check-in process when the patient arrives—so that the patient knows exactly what to expect, and so that you maximize the likelihood of the most accurate and up-to-date information heading downstream to your coders, billers, documentation specialists, and others involved in your RCM workflows.

"Waystar's automatic eligibility checking is a great thing to have. With just one push of a button, all of the information we need is right there."

Multi-provider practice, Waystar operations client survey

Have you experienced issues with payer responses? Waystar delivers improved accuracy and actionable eligibility verification through our proprietary Service Type Code mapping.

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2 Haines, Morgan. An Ounce of Prevention Pays Off: 90% of Denials are Preventable." At the Margins, December 2014.
3 ibid.
4 2016 CAQH Index
5 Tate, Alex. "Differences Between a Rejection and Denial in Medical Billing." www.electronichealthreporter.com, June 2015.

2 Make sure documentation lays the groundwork for success

Once the patient's appointment is complete and the clinical documentation moves downstream to the coder and/or biller, there's potential for a bottleneck.

For example, if back-office staff can't easily view the history and results of all actions taken by front-office staff, they may spend five to ten minutes simply digging in a different IT system for that information, and compiling it in a spreadsheet or other manual data entry software before they can move on in their workflow.

There are also a couple of ways that clinical documentation can slow things down in the back office. If the documentation doesn't support the "right" or most appropriate code that should be assigned—or if it simply doesn't contain the information that is required in order to code and bill for that type of encounter—the staff member(s) working the claim will have to send it back to the clinician. The clinician, in turn, having already provided their full documentation, will have to rack their brains trying to recall the additional detail, sometimes long after the fact.

It may even prove necessary to contact the patient for information or to request assistance getting the right additional records from another provider. If this can't be accomplished, the claim is likely to be denied—and the "best case" scenario is that it adds to staff's workload for that claim before the claim finally moves down the pipeline and is submitted to the payer.

3 Catch claims that will be denied

Once the patient's appointment is complete and the clinical documentation moves downstream to the coder and/or biller, there's potential for a bottleneck.

That's 15 to 45 additional days in AR for that claim, plus 15 to 45 more days to hear back once you've resubmitted the claim/appealed the denial, plus however long it took your staff to identify and work the denial. If you'd had a claims scrubbing engine that caught the error before the claim was ever submitted to the payer, those delays could have been avoided—a matter of minutes compared to an all but guaranteed 30 to 90 day delay if the claim reaches the payer and gets denied.

"Better reporting, better tracking, smoother customer payments and the ability to catch dirty claims in 30 minutes versus four weeks? For us, choosing and using Waystar has been a no-brainer."

Louisville Gastroenterology & Associates

And remember, if for any reason the denial is related to clinical detail or the encounter itself, that's an additional 30 to 90 days that the clinician and/or patient has to think back to recall the detail needed.

Consequently, you may want to leverage claims management software that automatically scrubs claims for these kinds of errors—software that understands your payer logic and updates automatically as this changes. That keeps you and your staff ahead of the curve—as opposed to chasing down denial reasons after the fact and having to contact payers to understand what exactly changed.

ZirMed's claim processing supports denial prevention through comprehensive edits that scrub every claim to identity errors and prevent payment roadblocks. In fact, a total of 98.5% of our claims are accepted by payers as "clean" and ready for processing on the first pass.

"We've seen a 20% increase in real-time identification of denials before claims go out the door—no time-consuming interaction with payer required."

Amy Myrick, Denial Team Lead, Johns Hopkins Homecare Group

"Reducing the time we spend conducting follow-up is a huge cost saving. The claims scrubbing and Simple Response® messages have dramatically decreased the time it takes to resolve rejections— and helped us reduce our AR days overall.

Valerie Johnston, CEO, Optimed Management

The bottom line

Once you're leveraging the tools and processes to help you prevent denials in the first place, you can further condense your denials cycle by focusing on how to resolve them expeditiously with payers. In part two of our Denials Series eBooks, Expediting Denial Resolution, we'll explore four strategies you can use to expedite denials resolution.

EXPLORE OUR ALL-IN-ONE PLATFORM

Eligibility

Verify insurance coverage to reduce claims rejections and denials

Revenue Integrity

Find missing charges and capture revenue you're due

Claim Management

Automatically submit and track claims, and reduce AR days with intelligent-driven workflow

Denial Management

Prevent denials and automate appeals

Contract Management

Gain control over payer negotiations, manage your contracts and recover owed revenue

Patient Financial Experience

Collect patient payments, determine propensity to pay and improve the patient experience

Agency Management

Get insights into outsourced agency effectiveness

Social Determinants of Health

Use data on broad factors that influence healthy to improve clinical outcomes

Get in touch today at
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ABOUT WAYSTAR

Waystar simplifies and unifies the healthcare revenue cycle with innovative, cloud-based technology. Together, our technology, data and client support streamline workflows and improve financials for our clients, so they can focus on their patients.