

A Guide to Understanding Common Denial Issues

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Continued increases in payor clinical claim denial rates place a heightened stress on a healthcare organization's revenue cycle and financial health. Clinical leaders who have a robust understanding of the denials landscape play a unique role toward improving organizational denial rates. This article introduces basic general denial trends, discusses denials terminology and common root causes for denials in relation to the clinical revenue cycle, and offers potential solutions for getting claims paid the first time.

KEY WORDS: Insurance claim processing; health insurance reimbursement; medical practice management; clinical coding; healthcare financing administration; healthcare economics; utilization review.

Denied payor claims in healthcare have increased steadily during the past decade,¹⁻³ with accounting industry data from more than 1,800 hospital systems nationally (representing approximately 200,000 providers) showing a general 18% increase from 2020 to the end of 2023,^{4,5} or approximately 12% of all initial claims were denied,⁵ which is well above the industry-recommended benchmark of <5%.⁶⁻⁸

While the exact financial impact varies by organization type and size, data show the percentage of lost total revenue for a median-size hospital (i.e., 360 beds) is estimated at twice that of an organization's denial rate: every 1% in denials translates to 2% of lost revenue.^{9,10}

Given denials' negative and potentially volatile impact on revenue cycles, not to mention the extra costs required to rework a claim (up to \$118 per claim¹¹), it is likely most clinical leaders attending finance meetings have engaged with non-clinical colleagues regarding this "clinically related" revenue issue.

While denial issues focus on denied payment for clinical services, the process and stakeholders involved before and during the process are much more expansive, extending into business areas that clinical leaders may have variable familiarity with.¹²⁻¹⁵

Effective claim denial management is not only about identifying and fixing, but also preventing future denials, as industry data suggest more than 83% of denials are avoidable^{16,17} and more than 40% of appealed denials get overturned.¹⁸ Placing a preventive focus on denials is more cost-effective for healthcare organizations and

payors, which can factor into more competitive payor contracting.¹⁹

Clinical leaders with a translational knowledge of denial management play a vital role in collaborating with fellow clinicians, business, finance, credentialing, billing, and payor colleagues toward improving organizational revenue streams, providing more timely patient care, and lessening provider burnout battling unneeded denials.²⁰

This review article is meant to equip clinical leaders with a more robust understanding of the revenue cycle process and denials' root causes relevant to the revenue cycle and provide respective solutions to improve organizational denial trends.

DISCUSSION

Background knowledge of the clinical revenue cycle is beneficial to understand how and where denials arise. Each step generally builds upon the previous. While descriptions can vary slightly in their terminology and groupings, Figure 1²⁰⁻²⁵ provides a high-level road map, focusing on: (1) the clinically related elements feeding into a claim, (2) subsequent claims submission and processing operations, and (3) post-payment, collections-focused processes, all of which funnel into denials management.

Denial Terminology

Payors provide a reason for a denial in their remittance advice, explanation of benefits, and/or claims reports in the form of Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs).²⁵⁻²⁸

CARCs include a “prefix” acronym that falls into the following broad categories: contractual obligations (CO), other adjustments (OA), payor-initiated reductions (PI), and patient responsibility (PR).²⁵⁻²⁸ A CARC also provides a numerical code and associated brief explanation for the denial (i.e., *PI-97; payment included in allowance for another*).

A RARC is supplemental and may not always appear on the remittance advice or claims reports. When available, a RARC provides further explanation regarding the CARC, as well as advice for resubmitting the claim.²⁸

CARCs can and do overlap, so combining similar CARCs from a data standpoint may make data analysis more manageable and point to broader trends. Additionally, some claims may be denied for several reasons. The following is a listing of common CARC denial categories, their available billing industry-reported prevalence ranges, and explanations, presented in general order of their revenue cycle occurrence:

- **Registration/Eligibility** (estimated 18–29% of denial causes^{17,29-31}): The patient/member information submitted on the claim does not match information the payor has on file, which can be because of incorrect demographic information, inactive/expired insurance coverage, co-insurance coverage issues, and/or the payor is not the primary payor.
- **Authorization** (13–42% of denials^{17,29,30}): There is a missing, incomplete, or unapproved, but contractually required pre-service (also known as prior-authorization) request for a provided service.
- **Provider Credentialing/Enrollment** (1% of denials¹⁷): The billing-provider is not recognized in the payor’s network or identified as associated with the billing organization. Credentialing denials can also relate to a provider’s permitted credentialing to provide a billed service (i.e., a generalist billing for a specialist-type procedure).
- **Medical Necessity/Level of Care** (6–14% of denials^{17,29,31}): The billed service is not covered by the payor’s medical policy and/or utilization management guidelines. When comparing reviewed encounter documentation to guideline criteria, the payor disagrees with the billed service’s medical and/or level of care necessity.
- **Missing Claim Information/Additional Documentation Needed** (5–16% of denials^{17,29}): This category relates to the data-entry portion of the billing and coding process. In essence, the claim form doesn’t have data the payor requires or something is wrong (i.e., a blank data field on the claim, missing patient/member’s social security number, demographic information, plan code, remark code, attachment, provider medical documentation, and/or other technical errors), which prevents further processing.
- **Billing/Coding** (3–18% of denials^{17,29,30}): Billing and coding errors relate to the claim not being filed correctly

according to a payor’s billing algorithms, where certain sequences and combinations of International Classification of Disease codes (ICD-10), Current Procedural Terminology codes (CPT), modifiers, and same-day services are expected, but incorrect. This commonly is where missing or incorrect modifier errors, separately billing for non-reimbursable bundled services, and/or limits on same-day services or billing providers may occur.

- **Timely Filing** (4–7% of denials¹⁷): Timely filing denials relates to when claims and/or appeals are submitted outside the payor’s contract-specified time limit for payment.
- **Adjudication**: Adjudication describes the comprehensive review process payors apply to claims to determine full versus adjusted, reduced, or denied payment (see Figure 1). Specifically in terms of denials, this also typically means the payor has requested further information to determine appropriate payment, with payment held until received. Adjudication may also include instances where the payor sends payment to the insured patient directly with the intention that the patient then pays the provider, but this is rare.
- **Contract-Related/Noncovered** (11% of denials¹⁷): Contract-related denials can appear similar to billing and coding errors; the difference is that the claim is submitted properly in terms of required information and coding, but it does not pass the contractual review portion of adjudication. Contract denials pertain to contractually unallowed services (i.e., non-covered or bundled), co-insurance adjustments, or differences in charged versus legislated fee schedule payment allowances.
- **Duplicate Claims**: Duplicate billing denials occur for same day/provider encounters and different-specialty providers submitting same-day claims under an organization’s shared tax identification number (TIN). A resubmitted and appealed claim (i.e., reprocessed claim) may also be categorized as a “duplicate claim” by a payor.

Managing Denials

Despite data showing that most denials are avoidable,^{16,17} industry survey data from more than 1,000 hospital systems nationally show that fewer than one-third of organizations focus resources on preventive management approaches.³⁰ A more cost-effective denial management strategy not only fixes, but also prevents errors and weaknesses in the claim submission process.^{25,26,31}

Best-practice denial management begins with understanding organizational denial data and trends.^{10,20,25,32} Denial reporting commonly is available through the electronic medical record (EMR) system, finance/billing department, and the payors themselves by contacting the payor representative. It is imperative to regularly review denial data for initial needs assessment, plus ongoing surveillance of new issues.

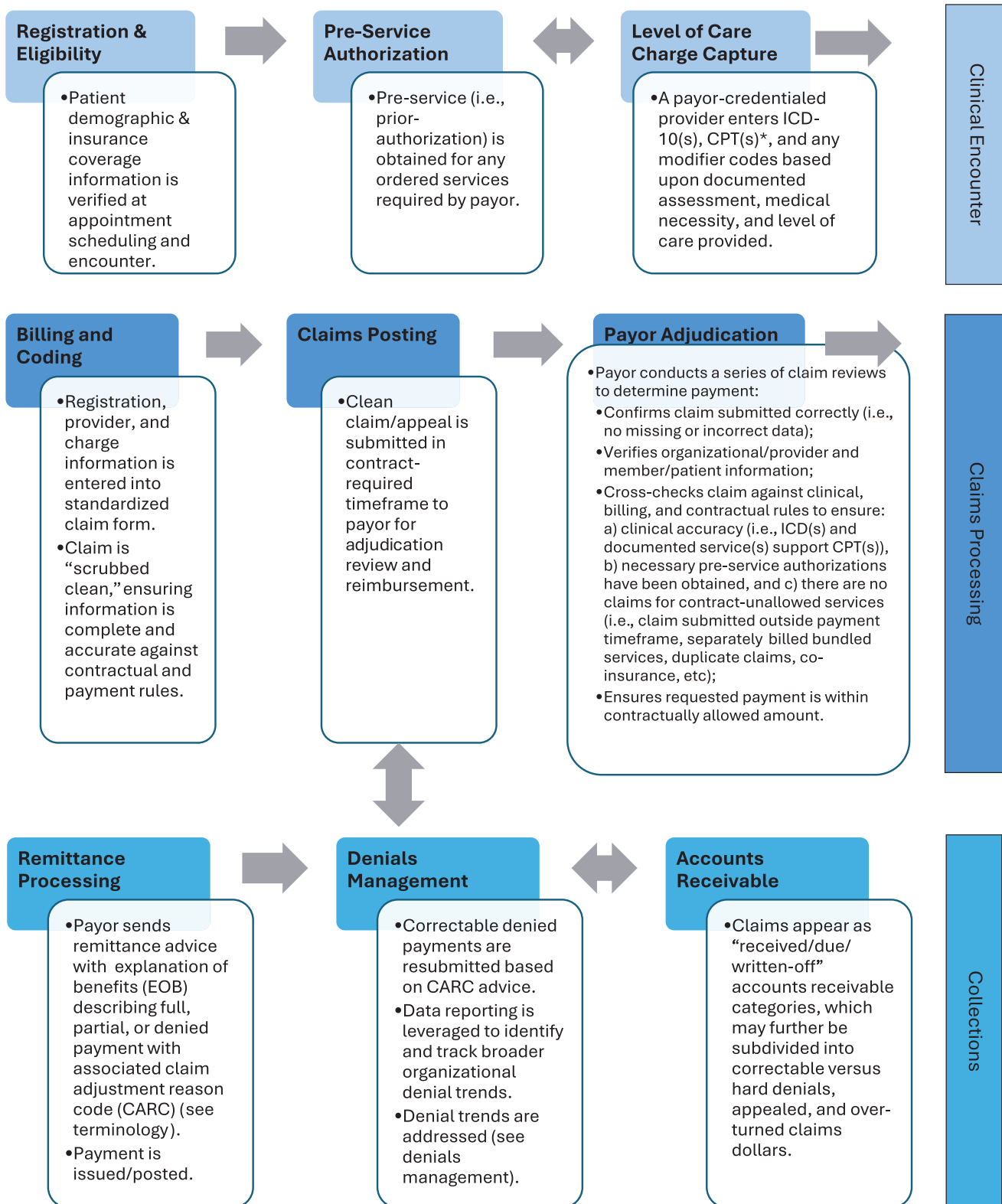


Figure 1. Clinical Revenue Cycle 20-25

*Abbreviations: ICD: International Classification of Disease, CPT®: Current Procedural Terminology.

As mentioned earlier, CARCs may benefit from further data refinement to make reporting more user-friendly and actionable.¹⁰ This is where a clinical leader's expertise can be helpful, working with analytics and finance colleagues to do a deep-dive data review of where and how CARCs intersect with underlying clinical revenue cycle processes toward more impactful analytics.

The following are some additional expert, professional society, and industry-based best-practices by denial category:

Registration and Eligibility: Registration and eligibility denials generally link to missing, incorrect, or unverified information associated with patient registration and health benefits confirmation processes.^{9,20,23,32,33,34} A policy requiring patients to confirm personal information and present their current insurance card at each visit for scanning into the EMR system for reference is recommended.^{20,33} Additionally, since a patient's insurance coverage may change between the time of appointment scheduling and the actual encounter date, establishing a reconfirmation process just before the encounter is prudent.²³

For hospitalizations with longer lengths of stay (i.e., neonatal intensive care units) that are prone to insurance coverage changes, it is similarly beneficial to create a member/payor eligibility reverification process.

Longer periods between providers completing documentation/billing and coders submitting claims (i.e., claims-post lag-times) also can affect eligibility issues since payor information can potentially change in a healthcare system's database after the encounter date.³⁴ Strategically working to shorten claims lags and/or having a formal process that cross-maps insurance coverage to the encounter date, especially for organizations with longer claims lag rates,¹⁷ helps reduce eligibility denials.

Authorization Issues: Denials from payors' pre-service/authorization requirements arise from three main causes: (1) the authorization was never requested, (2) the request was not approved before the service, and/or (3) the necessary authorization approval information was not submitted with the claim.^{9,20,25,34,35}

Providers should understand requirements for pre-service authorizations, including what payors and common services for their respective specialties require of them, their associated medical necessity criteria, and processes for requesting a pre-service authorization by commonly delegating to medical staff and/or navigating directly, usually through the payors' electronic authorization platform.³⁵ For patients with multiple comorbidities, it is also important that the listed diagnosis for the requested service clinically aligns, since authorization denials occur when a requested CPT and ICD-10 (i.e., diagnosis rationale for the requested procedure) don't clinically make sense.^{9,34,35}

Payors generally offer provider-oriented educational and practice resources through their provider manuals, websites,

newsletters, forums, and webinars, which organizations should pass along to providers.

Payor pre-service requirements change regularly; in addition to the above communications, it's important to verify with one's payor representative that notifications and updates are received.²⁰

Some payor communications may be more user-friendly and applicable to certain provider groups over others (i.e., only providing the numeric CPT® code, requiring further look-up of the actual procedure description itself to be meaningful). This is where a clinical leader's translational involvement can best direct and ensure the correct clinical audience is receiving understandable and actionable information efficiently.

Provider Credentialing/Enrollment: Managing credentialing/enrollment denials can be a stand-alone topic, with many vendors offering support services. Incorrect practice/billing information can trigger denials, as can an identified provider type/specialty being incorrect in payor databases,^{20,32} which can prompt adjudication systems to incorrectly deny specialty-associated CPTs.

Payors require correct, up-to-date provider information to be regularly reviewed and submitted by contractually specified timelines. Since this information may be entered by nonclinical support personal and/or providers who may not recognize how such information affects claims, educating staff and providers and establishing a process to review and ensure information accuracy is key.³²

Payor credentialing of newly hired providers deserves special mention, as timelines and requirements vary between payors and from clinical credentialing. To ensure timely credentialing, the steps involved may best be conceptualized into portions that are within and beyond an organization's direct control.

For example, obtaining state licensure, Medicaid approval (which is required before pursuing individual payor Medicaid managed care product credentialing), previous malpractice claim verification, and payor processing of provider credentialing largely depend on the turn-around times of these entities, which could take weeks to months.³² It is wise to strategically consider such timelines in provider offer letters and start dates.

Credentialing steps that are more within an organization's direct control include ensuring provider completion of credentialing items, promptly submitting items to appropriate entities, and proactively following up on any delays. For various reasons, including that the payor credentialing is not always user-friendly, it is not uncommon for providers to perceive payor credentialing as an extra nuisance to their primary clinical roles.

Providing pre-populated paperwork and supporting provider completion by written/in-person pre-onboarding walkthroughs, job-aides, checklists, resource contacts, and check-in processes, with associated deadlines and potential

implications for not doing so (i.e., postponing start dates), can improve turnaround times.

Medical Necessity/Level of Care Denials: Payors conduct utilization management reviews in three forms: (1) pre-service authorizations as discussed above, (2) concurrent reviews for hospitalization, skilled nursing, rehabilitation, and other payor-specified circumstances, and (3) post-service reviews, during which a procedure is reviewed for medical necessity and payment upon claim submission after the service has occurred.²¹

While there is a general trend toward more pre-service reviews, allowing patients and providers to know in advance if a service will be covered, post-service reviews are still common and pose an additional, after-the-fact risk for denials.

Providers ought to be familiar with payors' medical policies and their medical necessity requirements ahead of procedures and include medical necessity criteria in their documentation.^{18,33} Since some payors now leverage artificial intelligence to scan and compare providers' documentation against medical necessity criteria,³⁶⁻³⁸ documentation should reflect a payor's medical necessity verbiage as closely as possible. Employing procedural note templates, check-box listings, and/or other technology support solutions that include medical necessity criteria also can decrease denials.³³

Concurrent reviews not only use payor medical policy, but also more-so leverage a separate set of what are known as utilization management guidelines (i.e., Milliman Care³⁹ and Interqual Guidelines⁴⁰) to determine medical necessity and level of care coverage.^{21,23}

For example, for a premature neonate admitted to the NICU, such guidelines will determine an "intensity of care level" for the patient based on clinical status, needed ventilatory, feeding, intravenous medication, and other support factors, which if different from a provider's documentation and billed level of care, may result in a denial.³⁰

Similar to medical policy, providers should be familiar with, document, and bill according to these guidelines' met criteria (an organization's utilization review team commonly has access) as part of overall organizational billing optimization efforts.³³

Independent of concurrent reviews, level of care denials can occur when services provided and/or documented do not support the billed level of care (i.e., billing for a level IV Evaluation & Management service, when documentation only supports a level III).^{18,23,30} Research shows most providers need more billing education when it comes to billing for appropriate levels of care.^{10,11} Leveraging already-discussed provider education, EMR and vendor billing support, independent third-party billing audits, and provider performance feedback all help positively affect level of care denials.^{18,27,33}

Missing Information, Billing, and Coding Errors: Payors require a standardized claims submission format,

commonly leveraging appointment, insurance verification, EMR, and other data-feeds.^{18,23} In addition to providing ongoing coder training and performance audits to support accurate and complete coding data entry,^{7,15,21,30,32} understanding how, where, and what data feeds into claims, plus ensuring its completeness and accuracy, is imperative to prevent denials for missing information.¹⁸

For example, some denials can be avoided with proper EMR set-up to automatically submit encounter documentation with the claim, which payors may require.³² Given the technical complexities and many varying rules associated with payors' coding and claims submission, leveraging some version of what is referred to as claims editing, contract management, and/or "claims scrubbing" software that recognizes, fixes, and/or flags claims errors according to a payor's rules and requirements before submission is important to support biller/coder efficiency, reduce manual entry burden, and reduce potential errors.^{15,18,23,28,32} Numerous vendors offer such services and software.

Timely Filing: Clinical leaders should regularly monitor claims submission and posted performance data (i.e., lag reports)¹⁵ to ensure that initial and appealed claims are well within the variable, payor-specific deadlines, which can be found in payors' contracts and/or provider manuals.

In general, there are two main process steps that contribute to claims lags: (1) the time it takes for a provider to complete associated documentation, ICD-10, and CPT billing; and (2) the time it takes for a coder then to complete and submit the claim to the payor.

While the former is generally addressed via various provider documentation support such as scribes and billing service support, and organizational chart completion policies, the latter's causes can be more complex, ranging from bandwidth issues¹⁵ to claims being purposely held because of identified issues that need correction, such as provider awaiting payor credentialing, registration/eligibility issues, etc.

Adjudication: As part of overall timely filing strategies, any additional information requested by payors to process a held claim should be submitted within a payor's specified timely filing and appeal requirements.

Fee Schedule Accuracy: As part of contract-related denials, ensure there is a regular process to keep fee schedules current.⁶ Payor fee schedules are the contractually allowed amounts that a payor negotiates as payment for charged services. A denial may result if chargemasters do not align with payors' fee schedules.

Similar to authorization updates, verify your practice receives fee schedule updates from payors (typically via email and/or provider representative communications) on contractually specified frequencies. Although the actual upload and cross-mapping of fee schedules commonly lies within an organization's EMR and information technology business areas, because of the complexity of cross-mapping fee schedules to specific payors, insurance types,

clinical services, and provider-types, this is where a clinical leader's translational involvement can help confirm fee schedules are implemented correctly.

Finally, in regard to fee schedules and overall denials management strategies, when certain CPTs are denied, the potential reimbursement received may be less than the relative cost of reworking the denial; therefore, the cost-effectiveness of resubmitting versus perhaps writing-off certain denied CPTs should be assessed.²⁸

CONCLUSION

The increasing impact clinical denials have on financial health mandate that healthcare organizations must incorporate a denials management strategy as part of their overall revenue cycle processes. Further, given that denials arise because of a variety of causes that intersect and relate to clinical workflow, a clinical leader's involvement and translational expertise is a necessity for any truly comprehensive and effective organization denials management strategy.

Armed with a background knowledge of the revenue cycle and typical denial root causes and analyzing organization-specific denial data trends, clinical leaders may work with business colleagues to apply solutions toward successfully accomplishing their denials management goals. ■■

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