MO-ACHE Student Essay Award

Getting to Zero: A New Look at Denials Management and Deductible Collections

Saint Louis University

Expected Graduation December 2018

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November 30, 2018

Getting to Zero: A New Look at Denials Management and Deductible Collections

At $262 billion, annual insurance claim denials cost hospitals more than the 2017 revenues of Kaiser Permanente, Aetna, Humana, Tenet, and Healthcare Corporation America combined.[i] Additionally, in efforts to make health insurance more accessible, plans with higher deductibles have increased financial responsibility for patients. The increased deductibles have made the collections after insurance rate an impactful financial metric for health systems. As health systems prepare for the future, there is an opportunity to use proactive approaches to decrease rates of claim denials and uncollected deductible. This essay will offer a broad overview of the revenue cycle process, outline new trends that precipitated the change in deductible collections, then identify a proactive approach to managing insurance claim denials.

Revenue Cycle at a Glance

At first sight, it may seem as if the revenue cycle process begins after patients have been treated. However, it begins during the patient's initial interaction. The first step in any revenue cycle process is pre-registration which includes information collection and pre-authorization. Patient-friendly processes to collect information act as a proactive measure to prevent delays in the overall process. The U.S. government defines pre-authorization as a decision by a health insurer or plan that a prescription medication, procedure, service or equipment is medically necessary.[ii] In emergency situations, patients receive care before pre-registration, but typically pre-registration takes place before services are rendered.

The substance of this essay involves the next step, claims submission. There are three general categories for claims submission that include commercial insurance claims, public insurance claims, and self-pay claims; each category presents unique nuances. After patients receive care, health systems complete the complex exercise of coding information for all the services that were provided. Then, the information is submitted to insurers for payment. For claims that are approved, insurance providers pay a certain portion of the charges, and patients pay a co-payment. For uninsured and some underinsured patients, providers only request payment from patients. Typically, charges for these patients are drastically discounted. Co-payments and payments from uninsured and underinsured patients are collected via traditional avenues that are practiced in other industries.

Healthcare Reformation and Payment after Insurance

In efforts to make quality healthcare accessible, high deductible health plans (HDHP) have become more common. In 2018, 70 percent of large employers offered at least one HDHP.[iii] While the majority of the companies proved an option between an HDHP and traditional health plan, 5 percent only offer HDHPs[iv]. The IRS defines a high deductible health plan as one with a deductible of at least $1,350 for an individual or $2,700 for a family[v]. The out-of-pocket responsibilities for these plans can be as high as $6,650 for an individual or $13,300 for a family[vi]. A report from the Henry J. Kaiser Foundation found that the average deductible for people with employer coverage rose from $303 to $1,505 between 2006 and 2017; the increase between 2017 and 2018 was approximately $350.[vii] These accounts now have a significant impact on net patient revenue.

The significant increase in patient responsibility makes this portion of accounts receivable so impactful that it can skew budgeting predictions that weigh heavily on payer-mix. Now, health systems need a well-developed collections process for payments after commercial insurance. Health systems can start today by conducting focused assessments on these accounts and creating well-defined action plans to satisfy them. The first step is to compile all of the open accounts in this category and prioritized them based on the account's value and the amount of time that the account has been open. The next step is to identify the right team to assess each account and develop strategies to collect them. The final and perhaps most important step is to embed this practice into the system's operations. Well-structured reviews of these accounts will help health systems lessen the financial impact of HDHPs and close more of these accounts faster.

Denials Management Process

According to a study done by the American Academy of Family Physicians, the average claim denial rate across the healthcare industry is between 5 percent and 10 percent.[viii] The Advisory Board reported in 2014 that 90% of claim denials are avoidable[ix] and consistent account reviews that include multidisciplinary teams can drastically improve these denial rates. The first step is to compile denial claims and prioritize them based on the account's value and the amount of time left before the account is automatically denied. The next step is to compile multi-disciplinary teams that have representation from providers, revenue cycle, and administrative leaders. This is imperative because there is an extensive list of reason that account can be denied which can be simple adjustments like inaccurate patient information or missing physician signatures. Lastly, this process must be embedded in the revenue cycle's standard operations. These assessments should take place monthly on a large scale, then weekly to address nuances. Accountability and collaboration are the foundational pieces of this process and would improve outcomes.

With the decline in reimbursement and increased focus on cost-saving measures, these are two major opportunities for health systems to create operational infrastructures that both prepare for the future and increase revenue today. Although uncollected accounts and denied claim submission seem inevitable, health systems should continue to decrease those occurrences until they get to zero.

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[i] (Barkholz, 2017), (Stewart, 2018), (HealthCare.Gov, 2018)
[ii] (HealthCare.Gov, 2018)
[iii] (Miller, 2018)
[iv] (Miller, 2018)
[v] (HealthCare.Gov, 2018)
[vi] (HealthCare.Gov, 2018)
[vii] (Henry J. Kaiser Family Foundation, 2017)
[viii] (LaPointe, 2017)
[ix] (LaPointe, 2017)