Strategic Interventions:
Minor Errors Lead to Major Losses

Major revenue losses due to denials are affecting the financial health of hospitals large and small nationwide. With most claims errors originating in the scheduling and registration process, (an estimated 70% of a claim form is generated during the registration process), it is important to focus on areas of improvement that can be found there. A minor data entry error can lead to delays or denials of payments in the tens of thousands of dollars.

Denials management is often expensive and reactive. Focusing on ***denial prevention*** will improve cash flow and the hospital revenue cycle overall as a proactive process. While your hospital can significantly decrease the number of denials by being proactive, there will always be denials to manage. Focusing on the front-end processes and improving accuracy and workflow can help decrease preventable denials. Identifying trends in the types of denials your hospital is seeing is where you can start the process improvement.

The most common denials originating in the Patient Access department are:

- Missing or incorrect demographic information
- Inaccurate eligibility information
- Missing Authorization
- Medical Necessity

All are preventable denials that can cause an enormous impact on hospital cash flow.

Here are five "strategic interventions" you can implement to improve this area:

1. Staff that enter data need to have a work space that is conducive to accuracy.
Privacy is important not only for HIPAA concerns but also for the staff to be able to concentrate on the information they are collecting and entering. In addition, provide them with education related to the importance of this task so that they understand the need for accuracy. (For example, Registration Quality on hthu.net focuses on the general functions performed during the Registration process and the importance of the monitoring of Accuracy Rates and Auditing of Accounts; and the Patient Access Services 101 provides techniques and strategies to improve patient access workflow.) If this is an area of need in your hospital, involve your staff and ask for their input in the decision-making and improvement process.

2. Put policies in place regarding the collection and documentation of information obtained including what should be scanned into the record and what is appropriate for verification of information. Transposing two numbers in demographic information at the time of registration can cause chaos throughout the revenue cycle and result in denial of payment. Many registration errors can occur because the process is simply too difficult. In addition to the vast number of forms, our staff also face systems that can be complex. Policies not only help to clarify expectations and serve for training, but can also help to provide a reference tool on-the-job.

3. Consistently check eligibility for all patients for proactive denial prevention.
Use automated tools for eligibility checking. Determining the correct insurance, ID number, patient financial responsibility, medical necessity and network approval are all important steps in the process. Providing the tools for increased accuracy is a proactive approach needed in all hospitals. Whenever possible, eligibility should be checked prior to the patient's arrival. Scheduled patients should never arrive for their appointment without eligibility being checked beforehand. This step is important to ensuring payment for the scheduled procedure. Authorizations can be verified during this process eliminating yet another common denial. Claims billed without proper authorization can lead to final denials with no appeal possibility.

4. Watch for trends in medical necessity denials for all payers.
Medical necessity is not only for Medicare patients. Many insurances have now developed policies covering testing, like the coverage determinations initially only used by CMS. When a trend is identified for a payer other than Medicare, use that information to develop processes on the front end to avoid similar future denials. Utilize Advanced Beneficiary Notices for Medicare patients and check with other payers to see what should be used to notify their patients of their financial responsibility for testing that is not considered medically necessary.

5. Finally, once the claims get to the billing system, an up-to-date claims scrubber should be used. Claim scrubbers can reduce headaches and hours of phone time with payors, and can help you to submit clean and accurate claims and get paid faster. The billing staff should be knowledgeable and diligent in ensuring claims are transmitted only after a rigorous screening process.

By being proactive instead of reactive in denials management, many hospital will see the revenue cycle become more efficient- increasing productivity, decreasing denials and increasing cash.

Take a look; how many of these areas does your team perform consistently? What areas do you need to implement? If you have questions. contact Sandy Sage at sandy.sage@hometownhealthonline.com.

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