The Essentials of a Successful Denials Management Team

By Tammy Combs RN, MSN, CDIP, CCS, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer
Objectives

• Define denials management
• Identify the departments who should be part of the denials management team
• Review the top reasons a claim is denied
• Assess when to appeal a denial
• Identify the key components of a concrete appeals letter
• Recognize the information gained from tracking denied claims
• Discover how to prevent denials
• Review the key elements of denials management team policy
Denials Management Process

Denials Specialists Receives a Denied Claim

Denied Claim Reviewed by Denials Team

Agree with Denied Claim

- Reimburse Payer

Disagree with the Denied Claim

- Begin Appeal Process
Key Members of the Denials Management Team

- Denials Specialist
- Case Manager
- Quality and/or Compliance specialist
- Clinical Documentation Improvement (CDI) Professional
- Physician Advisor
- HIM Coding and Record Management Professionals
Top Reasons for Denied Claims

- Medical Necessity
- Missing Documentation
- Missing Clinical Evidence/Treatment
- Inaccurate Code Assignment
Medical Necessity

• Admission criteria
• Invasive Procedure Criteria
• Inpatient only Procedures
• Coverage Guidelines
• Published Clinical Criteria
• DRG Validation Guidelines
• Coding Guidelines
• Other criteria such as practice guidelines that are widely accepted by the medical community
Case Study
Missing Documentation

• Present on Admission
• Acuity Level
  – Acute, Chronic, Acute on Chronic
• Type
  – Systolic/Diastolic Congestive Heart Failure (CHF)
  – Gram Negative/Aspiration Pneumonia
• Inconsistency within the Provider Notes
Case Study
Missing Clinical Evidence/Treatment

• Clinical Evidence
  – Laboratory Findings
  – Radiological Findings
  – Assessments

• Treatment
  – Medication
  – Monitoring
  – Consultations
Case Scenario
Inaccurate Code Assignment

• Official Guidelines for Coding and Reporting
  – Selection of Principal Diagnosis
  – Selection of Principal Procedure
    • Surgical Hierarchy
  – Secondary Code Assignment
  – Setting Specific Guidelines
    • Possible/Probable Diagnosis
When to Appeal a Denied Claim

1. Assess the Reason for the Denial
2. Health Record Review
3. Data Collection
4. Subject Matter Expert Collaboration
5. Case Outline
Concrete Appeals Letter

• Patient Identifiers
• Restatement of the Denial Reason
• Explanation for the Appeal
• Supporting Evidence
• Compliance or Regulatory Guidance
• Requested Outcome
Tracking Data from Denied Claims

• Denial Rate
• Denial Reasons
• Appeal Outcomes
• Identify High Risk Diagnoses
• Establish Clinical Guidelines
Continuing Education

• Formal
  – Staff Meetings
  – Department Meetings
  – Grand Rounds

• Informal
  – One on One Meetings
  – Queries
Denial Prevention

• Clinical Documentation Improvement Programs
  – Supports Accurate Documentation
  – Target High Risk Diagnoses
• Ongoing Education
• Tip Sheets
Denial Management Policies and Procedures

• Provides Guidance
• Clear and Concise
• Location
• Detailed
References

References

• Inpatient or Outpatient Hospital Status Affects Your Cost. Retrieved from: https://www.medicare.gov/what-medicare-covers/part-a/inpatient-or-outpatient.html


Questions