Summary
A strong revenue stream case is made for intelligent outsourcing of hospital denials – up to 20% more effective in reimbursement terms – versus the strategy of only in-sourcing, with or without a denial software “solution.” The author employs in her argument decades of experience with all denial types, payers, providers and technologies.
Denials cost health care organizations about 3% of their net revenue stream, according to Washington, DC-based, global health care research, technology and consulting firm, The Advisory Board Company.\(^1\) In many cases, this is the difference between a positive balance sheet and a negative one.

What appeared a decade ago as a tolerable cost of business by health care providers with only an internal denials team (and perhaps a denials software package) now can be viewed as “leaving money on the table,” a real loss of cash flow and a less-than-optimal operational efficiency.

The Denial Problem is Growing

Among U.S. health care providers, gross charges denied by payers have grown to an alarming 15% - 20% of the nominal billing value of all claims submitted, according to recent estimates.\(^2\) Even with a very conservative 10% rate for gross charges denied for both inpatient and outpatient accounts, the following data result for some typical hospitals:

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Beds</th>
<th>Annual billings from patient treatment</th>
<th>Estimated annual denials cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>185</td>
<td>$63 mil</td>
<td>$6.3 mil</td>
</tr>
<tr>
<td>Teaching</td>
<td>480</td>
<td>$660 mil</td>
<td>$66 mil</td>
</tr>
<tr>
<td>Health system</td>
<td>1,100</td>
<td>$2,610 mil</td>
<td>$261 mil</td>
</tr>
</tbody>
</table>

And this is happening in a health care environment increasingly constrained by funding reductions and matched by escalating demands for every incremental dollar of reimbursement and every dollar of opportunity cost avoidance.

And now, with the implementation of the Affordable Care Act (ACA), almost 45 million more people will be eligible for Medicaid or coverage from insurance marketplaces (“exchanges”).\(^3\)

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Although there are initiatives underway to simplify Medicaid and other coverage application processes, it is reasonable to anticipate a sizable increase in the demand on hospital staff for eligibility screening, and very few providers have the necessary resources to add and sufficiently train that much staff.

On top of this, U.S. adoption of The International Classification of Diseases Tenth Revision (ICD-10) means clinical documentation for billing submissions will become even more complex. Imminent ICD-10 implementation entails a seven-fold increase in procedure and diagnostic codes, with the number of inpatient procedure codes alone increasing by more than 1,700%.

No matter how experienced a hospital staff, the magnitude of ICD-10 changes will require added learning and labor intensity, increasing the potential for a markedly larger incidence of denials. Consider that the cost to hospitals just to gather information to analyze a denial can range from $50 to well over $100 per case, and the negative financial impact has the potential to be quite large. Similar staff pressures among payers support this theory as well.

The Shortcomings of In-sourcing as the Sole Denial Management Strategy

There is no doubt providers’ internal denial teams have proved generally successful since they became a staple of hospital denial strategies in the late 1990s, and experience shows they overturn, on average, a bit less than 50% of all denials referred to them… or about one of every two.

However, roughly 67% of all denials are appealable⁴, suggesting hospitals should be setting their expectations a bit higher… nearer two of every three referred denials.

Also, most hospital denial teams have different degrees of expertise with varying types of denials and payers, so overall success rates may not hold true for some key kinds of denials or important payers that may present special problems. For example, of the four general kinds of denials, medical necessity denials amount to only 7%⁵, yet are characterized by the largest charges and the highest probability of appeal viability… so if a hospital denial team’s expertise in any way is lacking in this area, the financial consequences can be quite negative. Another example is found in authorization denials, which amount to around 28%⁶ of the mix. If a denial team has any backlog of denials that take precedence, many authorization denials

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⁴ Driving the Denials Management Initiative, ob. cit., page 8
⁵ Based upon data collected over years of denied account analysis and appeal for various hospitals across numerous states by Human Arc, 1457 East 40th Street, Cleveland, OH 44103
⁶ Ibid
will lose their appeal viability due to much shorter appeal time windows.

In addition, analysis of denials within these teams is normally a labor-intensive process slowed by staff members’ competing priorities. And the opportunity cost to the hospital of taking highly skilled staff members away from their core areas of expertise and revenue productivity is another negative factor that cannot be minimized.

Software by itself generally does less than buyers would hope. Hospitals since the 1990s often have made large capital outlays for denial software systems in the assumption that technology translates directly to cost efficiencies. Although it is estimated that a good denials software package can reduce denials incidence around 6% by identifying major sources and frequencies, software alone does not address the challenges inherent in the construction of the appeal package, its submission or follow-up with payer agencies or companies. Hence, a 6% reduction in denials compares poorly against an 18% average reduction made possible by combining that software technology with dedicated denial staff assistance and benchmarking performance against today’s leading industry standards.

It’s virtually impossible to attach hard numbers to effectiveness or cost efficiency of the denial team/denial software strategy. Nevertheless, it is possible to say this approach – employed to the exclusion of others – can cost providers significantly. This is especially the case versus intelligent outsourcing of at least the most troublesome part of denials.

**The Case for Adding Intelligent Denial Management Outsourcing as a Strategy**

There is a big difference between outsourcing of denials and intelligent outsourcing of denials. Intelligent outsourcing can be defined as referring denials of especially difficult kinds – and from any difficult payers – to an external service skilled not only in successful denial appeal but also working with the provider to assess its denial situation and processes. In short, intelligent outsourcing helps reduce denial incidence as close to its absolute minimum as possible and, in addition, helps the provider become better positioned to successfully negotiate with its payers.

Decades of practical experience with outsourced denial management strongly supports the following characteristics are what today’s health care provider should expect in an intelligent denial management vendor:

1. **People experience:** the ability to bring an impressive array of professional experience to the table from the clinical, technical (billing/coding), and public and private payer spheres, including staff RNs and certified coding experts – in aggregate, a lot of dedicated experience with every type and source of denial. In addition, these professionals should have the expertise to speed data transfer and obviate errors between provider, vendor and payer, resulting in faster referral, processing and reimbursement.
2. **Performance:** the demonstrated ability to achieve success appealing up to and in some cases beyond 60% of all denied claims referred to it (or up to, and in some cases beyond, 90% of accounts deemed viable for appeal), whether inpatient, outpatient or ER accounts, pre- or post-billing, regardless of payer or denial type – whether authorization, documentation, medical necessity or technical billing issues. This also entails the ability to consult on and appeal RAC, MIC and commercial audits as well as conventional denials.

Therefore, when intelligent outsourcing raises a hospital’s denial appeal success rate from around 50% upward to 60% of the gross value of the denied billings, the result is a significant boost in positive cash flow (around 6%) and a minimization of cash “left on the table” due to truly unrecoverable billings from legitimate denials.

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Beds</th>
<th>Annual billings from patient treatment</th>
<th>Estimated annual denials cost</th>
<th>Est. added cash with just denials team and software</th>
<th>Same, but with outsourced denials vendor too</th>
<th>Incremental positive cash flow with outsourced vendor too</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>185</td>
<td>$63 mil</td>
<td>$6.3 mil</td>
<td>$3.15 mil</td>
<td>$3.8 mil</td>
<td>$650,000</td>
</tr>
<tr>
<td>Teaching</td>
<td>480</td>
<td>$660 mil</td>
<td>$66 mil</td>
<td>$33 mil</td>
<td>$39.6 mil</td>
<td>$6.6 mil</td>
</tr>
<tr>
<td>Health system</td>
<td>1,100</td>
<td>$2,610 mil</td>
<td>$261 mil</td>
<td>$130.5 mil</td>
<td>$156.6 mil</td>
<td>$26.1 mil</td>
</tr>
</tbody>
</table>

3. **Flexibility to customize to meet client preferences:** the willingness to work any segment of the denial mix – primary or secondary – that the hospital’s team refers. It’s important to keep in mind that most outsource services will not handle only part of a denials mix, even though their expertise may be limited to clinical or billing denials.

4. **Timeliness:** the technology and ability to successfully appeal within tight time limits and follow up with payers to verify correct payment in all cases.

5. **A real solution, not a band aid:** a real solution doesn’t just recover cash by reversing existing denied claims; it combines denial prevention with denial management. It is estimated that around 90% of all denials are preventable\(^7\), so the vendor’s objective should be to provide all data the client needs to analyze the root causes of its denials/audits, understand how to avoid them, and reduce future denials to a minimum. This has to include an audit to validate clients’ processes, which will help them negotiate more favorably with payers. Current Procedure Terminology (CPT) code reports are a useful tool in this process to help clients identify denial sources and frequencies, helping them improve their processes.

\(^7\) *Driving the Denials Management Initiative*, ob. cit., page 9
6. **Best-in-class, 24/7 reporting, online and free of charge:** so providers can be apprised anytime on claim status, vendor and hospital staff performance, and trend reports for specific payers, departments and even physicians. Intelligent denial management means intelligent providers who know how well their present denials are being appealed and how well their future denials are being minimized.

7. **Mutually set objectives:** measurable denial management objectives, set cooperatively between the provider and the vendor, based upon clear evaluation benchmarks and performance indicators such as gross and net days outstanding, aged A/R as a share of billed A/R, cash collections, billing turnaround times, conversion ratios, follow-up times, costs to collect and bad debt ratios.

**Conclusion**

Outsourcing denial management avoids important issues often present in the denial in-sourcing model, especially if the latter is the only tool a hospital actively employs to contest and reduce denials. Although any denial management vendor can satisfy one or several of the aforementioned conditions, it takes a vendor with extensive experience in denial management and highly skilled resources to deliver consistently on all seven of these criteria. It is our belief that, at present, only a single vendor is able to do just that – Human Arc’s PayerLogic™ Denial Solutions (1457 East 40th Street, Cleveland, OH 44103, www.humanarc.com, 800.828.6453). Therefore, it is employed here as a benchmark for intelligent outsourced denial management.

**About the Author**

Ms. Holly Pelaia is Vice President of Operations, Hospital Business, for Human Arc, a national innovation leader in reimbursement and other revenue enhancement services for hospitals and health plans. Reporting to her are all operational leadership and staff for the company’s three main hospital service groups: Eligibility Enrollment Solutions™, PayerLogic Solutions and Disproportionate Share Services. Ms. Pelaia is an expert in the field of denials management and reduction strategies. An industry-recognized speaker, she is a Northeast Ohio HFMA board member and co-chair of the Northeast Ohio HFMA Patient Financial Services Committee. In 2012 she was recognized for her work with the William G. Follmer Bronze award from the HFMA Northeast Ohio Chapter.