2022
Denials Insights

Insights and improvement tactics for healthcare's most challenging reimbursement issues

SIFT® HEALTHCARE

Solve Healthcare's Toughest Reimbursement Issues with Advanced Analytics and Machine Learning

This annual review of claims and remittance data conducted by Sift's Denials Experts examines unique aspects of payer denials in 2022 - investigating root causes and reasons for backlogs and missed revenue - and provides actionable recommendations for prevention, optimizing workflows and improving staff efficiency.

With these insights in hand, your team will be equipped to implement processes that accelerate payments and reduceoverall denials.

We wish you insightful reading.

Insight:

Q4 Saw Increases in Additional Information Request Denials

In the last quarter of 2022, Sift analysts tracked spikes in documentation request denials requesting medical records. While this is a high overturn denial, it is also high-touch and requires manual re-work.

Takeaway:

CARC 252 denials for "An attachment/other documentation is required to adjudicate this claim/service," is a smart place to start, and the first of the year is a great time to get a handle on how CARC 252 denial codes are managed at your organization. **Steps to take include:**

1. **Review your overturn rates for CARC 252.**

   If you see high overturn rates for CARC 252, consider having a direct conversation with your payer counterparts. Request a review of their practices in issuing additional documentation denials. On both sides, there is likely unnecessary administrative burdens to re-work these claims (that are ultimately being paid).

2. **Look for connections between CARC 252 denials and registration/eligibility denials.**

   RARC MA04 ('Secondary Payment cannot be considered without payment information from primary payer') often indicates that the remitting payer doesn't believe they should be primary. Sift has worked with clients whose total CARC 252 denials consisted of 33% MA04 remark codes, which comprise only 4% of gross denied dollars. Understanding the value of these denials is essential in determining which team should manage the initial review and how to prioritize staff follow-up efforts optimally.

Insight:

Understanding Root Causes of CARC 197 Denials Speeds Response Time

CARC 197 is generally used by payers to deny for authorization issues and is a persistent pain point for denials prevention and management. Sift's denial experts have found that the code is often the result of one of three causes: payer responsible, payer/provider responsible, and provider responsible.

Takeaway:

Group your CARC 197 denials into responsible party categories to streamline response methods and accelerate response time. **These categories include:**

1. Payer responsible:

Sift has found that in many cases, a provider and their staff can follow the provided payer guidelines/information and still end up with a denial. Examples we saw in 2022 included:

- Authorization is secured via payer portal but not acknowledged in the payer claims processing system.
- Payer portal indicates no authorization is required for a procedure but then adjudicates an authorization denial once the procedure is billed.
- Payer denies "non-reimbursable" surgical add-on codes that should not have required authorization.

For payer responsible CARC 197 denials, it is important to quickly identify problem payers and claim types to engage your payer rep to stop this behavior from impacting future claims and to escalate the roster of inappropriately denied claims.

2. Payer/provider responsible:

These are the most challenging to diagnose and improve as there are usually multiple points at which the denial can trigger. Examples of this category include:

- Authorization was secured from the payer and scanned into the EMR but did not end up being transmitted on the UB/837.
- For patients whose treatment extends beyond the original authorization, the submission of an 'old' authorization number instead of the 'current' authorization number on the claim form.

In both of the above payer/provider responsible CARC 197 examples, having data on what was billed on the 837s equips providers to work with their EMR/RCM IT counterparts to introduce new logic or edits to mitigate these denials in the future. It helps to have an individual or small team who is well-versed in the authorization workflows and guidelines to assist in reviewing these cases.

3. Provider responsible:

While authorizations are commonly a top priority for process improvement, the current payer guidelines make it difficult to completely eliminate lack of authorization denials. **However, access to advanced analytics enables providers to identify the service lines and locations that provide the greatest opportunities to reduce authorization denials.** Some examples of successful data-based observations include:

- The identification of registration/eligibility denials that result in subsequent authorization denials due to the incorrect payer being listed as primary at the time of service. This tends to happen if a patient has Medicare and a commercial payer.
- The identification of repetitive denials in recurring series areas like medical oncology, radiation oncology. and OP rehab.

Insight:

Automated Messaging Can Speed Up CARC 227 Denial Process

Denial CARC Code 227, 'Information requested from patient/insured/responsible party was not provided or was insufficient/incomplete,' was a challenging denial for Sift clients in 2022 because it often requires information from the patient.

In addition to the CARC, payers should provide a more detailed RARC to specify the requested information. This allows health systems to more intelligently facilitate the follow-up of these denials based on the type of information being requested versus simply pushing the balance to the patient.

In certain CARC 227 denials, the follow-up may not require input from the patient (e.g., RARC MA92 – 'Missing Plan Info for Other Insurance' or N479 – 'Missing EOB'), so health systems can likely handle the denial like other Additional Information Request denials.

Alternatively, RARCs such as N686 – 'Missing/Incomplete/Invalid Questionnaire' or N179 – 'Pending Info from Member' likely require action on behalf of the patient. While it requires additional configuration in coordination with your EMR/RCM team, **those scenarios present opportunities to set up automations to queue up letters or push patient portal messages that notify patients of the claim denial proactively instead of waiting for your staff to touch/review the account.**

Takeaway:

In 2023, look at the impact of these denials and set up processes to minimize your staff's time spent working on them. Keep additional patient information requests from causing unnecessary headaches for your team.

Insight:

Prevent Dreaded CARC 22 "COB" Denials by Sequencing Medicaid Last

CARC 22, 'Another payer per coordination of benefits may cover care,' was consistently a top denial code in 2022 for Medicaid payments.

A quick win many organizations have already implemented is to verify that Medicaid is sequenced last in the payer filing order on an account before billing. However, how closely are you and your staff monitoring the instances where a claim is billed to Medicaid only to receive the dreaded CARC 22 COB denial indicating that there is likely another payer to bill instead of Medicaid for reimbursement?

One Sift client showed that, over a 10-month span, a different payer ended up being re-billed in 60% of CARC 22 denial cases.

Takeaway:

For organizations that operate a "Single Billing Office," there is likely an opportunity to review existing workflows to increase efficiency in working these denials. Imagine a patient who entered through the ED, resulting in both a facility and professional claim, who then required additional outpatient visits in the following days/weeks. If the original financial clearance only identified the patient as Medicaid eligible, this could result in the receipt of multiple claim denials.

Instead of working each claim denial individually, an organization could implement a new standard process to sort COB denials by patient MRN. Therefore, a single review could result in multiple overturn opportunities. Additionally, for organizations that use Epic, the Coverage Manager functionality allows the administrator to flag unbilled hospital accounts that have Medicaid listed as primary payer with an edit or billing indicator so that they can be reviewed/updated if new coverages are added to the patient or guarantor prior to billing. This minimizes the risk of an additional denial being received.

Additional coordination claims can be painful. Identifying them quickly enables your team to address them appropriately. Sift's Rev/Track Denials Dashboards make it easy to identify these claims to improve your coordination of benefits denials performance.

Insight:

Low-Dollar CARC 11 Denials Can Require High Staff Hours

In 2022, some Sift clients saw CARC 11 denials, 'diagnosis inconsistent with procedure,' increase month-to-month. By volume, the top CPT codes for CARC 11 denials tend to be lab codes, many of which are lower dollar tests, commonly performed on episodic outpatient accounts. These denials have a low likelihood of being overturned – and, even if they are overturned, they typically pay a small amount in comparison to other services.

Takeaway:

It is worth reviewing these denials to determine if you can prevent them through 1) root cause analysis via provider education or 2) reviewing OP lab order scheduling and medical necessity check functionality in your EMR.

Consider Outsourcing CARC 11 Denials

It may also be worth de-prioritizing these for denials overturn follow-up or proactively outsourcing them to an existing third-party insurance follow-up partner. This approach helps ensure that low-dollar, high-volume denials are being triaged for process improvement while minimizing the number of accounts being routed to your more skilled internal denials appeal staff.

Insight:

CARC 4 denials are easy to address.

CARC 4 denials can demonstrate either a gap in your pre-bill edits or an indication that the payer rules or behavior changed.

Takeaway:

If you notice an uptick in CARC 4 denials, review the payer mix associated with them and engage your revenue integrity or coding team to determine if there were any recent changes to modifier requirements for the codes in question - and whether they agree that a modifier is appropriate.

- If the review determines a modifier should be added, work with your EMR/RCM team to implement a new edit specific to the CPT and modifier required.
- If the review determines the modifier is inappropriate or inconclusive, bring the list of denied codes to your payer representative to obtain the criteria and rationale they are using to deny these claims.

Insight:

IP 50 Denials are High Volume and have a Significantly Low Overturn Rate

For many payers, IP 50 denials, "Non-Covered Medical Necessity," make up a notable portion of the monthly claims they deny. For some payers that Sift tracked in 2022, this code drives denial volume and has a significantly low overturn rate (sometimes under 25%).

For inpatient billed accounts that ultimately cannot be overturned and require rebill at a lower level of care, it is important to leverage your data to identify when to downgrade before billing because, in these instances, downgrading on these accounts may accelerate cash collections and reduce rework efforts.

Takeaway:

Explore Proactive Downgrades to Avoid IP 50 Denials

Beyond managing your team's time, it's worth identifying denial volume and overturn patterns for CARC 50 and engaging your payer representatives to determine if there are opportunities to collaborate on the reduction of these "non-preventable" denials.

Sift's Rev/Track analytics tools, predictive models and team of revenue cycle denials reporting experts can help you track these denial patterns and determine how to prioritize them to drive the most ROI for your organization.

Insight:

Prioritize Late Charge Automation to Reduce Duplicate CARC 18 Denials

Duplicate denials can be a lagging indicator of late replacement claim automation needing review. In addition to increasing the volume of CARC 18 denials being posted into your EMR, this may also result in payers sending takebacks/recoupments as they review the new submission for possible additional reasons to delay or deny payment.

In reviewing duplicate denials for clients, Sift has found that many of these denials happen on XX7 type of bill claims (late replacement).

Takeaway:

For inpatient claims, CARC 18 denials often have small dollar 'ancillary' charges like lab fees that do not change the expected payment. Unless payer contracts or regulations stipulate that the provider must send a replacement claim, **these may be good candidates for late charge automation efforts to reduce the number of replacement claims being sent for these scenarios.**

Insight:

Not all 16s are Created Equal

Denial Code 16, 'Lacks Info Needed For Adjudication,' varies widely in its impact. Determining its overturn potential, or how to resolve the denial, heavily depends on its associated remark code, which provides further information into the nature of the denial.

- Sometimes the remark code notes a coding denial because of a missing/incomplete or invalid procedure, revenue code, NDC code, or principal diagnosis.
- Other times, the remark code indicates a documentation denial, either from missing provider information (like itemized bill, primary payer EOB info, etc.) or patient/subscriber information, which is more of an eligibility denial.

For 16s, the associated remark codes inform how to work the denied accounts.
The remark code can especially inform denial prevention process improvements that your team should implement to increase cash acceleration.

Takeaway:

An easy process improvement is automatically attaching primary EOB info or itemized bills to secondary payers who commonly deny with remarks N4 and N26.

Some 16-denied accounts are simply payer payment delay tactics

which you should address with your payer representative. For example, many organizations that Sift works with have very high overturn frequency (70%+) for specific remark codes, including:

- **N20:** This remark notes that 'Service not payable with other service rendered on the same date,' when the service level charge is appropriate and reimbursable.
- **N779:** This remark says replacement/void claims can only be submitted once the original claim is resolved. However, the payer notes indicate that staff was instructed to resubmit the claim.

Sift Suggestion:

Categorizing 16-denied accounts based on the remark code improves your reporting. Instead of calling all 16 denials "billing" denials, remark codes enable you to bucket denials based on the root cause, such as eligibility, coding, and non-covered. Remark codes also help you understand whether the denied account should be prioritized as an appeal or in a denial prevention workflow.

Some 16s need to be prevented, and some need to be overturned.

How do you tell the difference? And how do you wrangle remark codes into your reporting? Sift's machine learning platform prioritizes 16 denials based on their likelihood of being overturned—without your team having to build extensive remark-level logic to stratify and report on these denials.

Insight:

Handling Multiple Eligibility Denials by Patient Rather than Code can Accelerate Cashflow

It's common to have patients who have multiple eligibility denials in short periods of time —especially for PT, medical oncology and radiation oncology. **Sift experts recently analyzed registration denials within a large health system's medical oncology service line and found that 21% of the patients who had more than one account denied for a registration/eligibility denial code resulted in 44% of the overall denied hospital accounts by volume and 61% of the gross denied dollars.**

Based on Sift's Machine Learning models, these denials have a high likelihood of overturn, which indicates opportunities to accelerate cash by working these denials by patient—rather than denial code—and determining root causes to identify process and/or technology gaps that can be addressed.

Takeaway:

The beginning of the calendar year is a great time to do a check and ensure you have the appropriate procedures in place to handle these denials. Some analysis points Sift recommends:

1. **Tracking registration and eligibility denials by the volume of denied transactions, accounts, and patients**
2. **Ensuring you understand how common it is for a single patient to result in multiple eligibility denials, which require multiple touches and follow-ups from your team**
3. **Grouping registration/eligibility denials (common CARC: 22, 26, 27, 109, 200) by the unique number of patients**

Insight:

Protection from Payer Takebacks Requires Data

A growing and concerning trend is an increase in takebacks, or "clawbacks," from payers who are doing retrospective reviews and taking back payments. It is becoming essential for health systems to protect initial payments, which requires data.

Recently Sift's data analysis uncovered over $500K in Blue Cross payer takebacks on AR aged 365+ from discharge. In addition to the takeback, the payer provided a full denial adjudication with CARC 50—Medical Necessity.

Takeaway:

Sift's daily aggregation of your 835 and 837 claim data allows you to see the complete timeline of events that precede and follow a payer takeback. This unique view enables you to understand why your insurance AR aging >365 experienced an unexpected spike and equips you with data to bring to your payer counterparts.

Insight:

Procedure Change Denials are Common and Preventable

In 2022, the Sift analytics team saw a high volume of authorization denials driven by procedure changes. These denials represent the most significant controllable authorization denial.

Example:

- **A patient is scheduled for an MRI of the head without contrast.**
- **The HMO requires authorization, which is obtained.**
- **The patient's neck ends up hurting, so the procedure changes to an MRI of the head and neck with contrast.**
- **The procedure performed is different than authorized; therefore there is a denial.**

In a case such as the above, it is important to contact the payer and update the authorization to avoid denial for billing a CPT that was not previously authorized. However, identifying instances where procedure changes are likely to result in denial is difficult. Some questions to ask:

- **Are these procedures initially scheduled to avoid the pre-authorization processes, or are the clinical conditions of the patient truly changing during the procedure/test?**
- **Can you work with your top payers to set up a longer retro-authorization window or a cleaner re-bill process to avoid duplicate denials?**
- **Can you work with coding to obtain near-real-time data to match against the referral/scheduled procedure to flag these earlier for retro-authorization?**

Knowing which areas and service lines drive authorization denials allows for process updates to close gaps in workflows that can lead to these denials.

Sift can help in two ways:

1. **Advanced Analytics.**

   By combining coding data with claim remittance data, Sift helps pinpoint the root causes of denials and provides detailed (but digestible) intel on the areas and service lines contributing to authorization denials, along with actionable recommendations to improve processes.

2. **Denial Overturn Predictions.**

   Sift's predictive models proactively identify which claim denials are most likely to be overturned. This intelligence simplifies the decision tree around pursuing an appeal immediately or performing further research on whether the claim payer allows for retro-authorization.

SIFT
HEALTHCARE

2022
Denials Insights

Empowered Revenue Cycle with Sift

Sift's ML-driven payments intelligence delivers integrated recommendations for:

- **Denials Management**
- **A/R Follow-up**
- **Denials Prevention**
- **Patient Payments**
- **And more!**

Empowering Decisions with Data

Sift Healthcare's machine learning continuously mines your entire revenue cycle data stream, providing insights that deliver clarity and actionable next steps. Through Sift's advanced decision-support solutions, healthcare organizations achieve a higher level of data visibility and payments intelligence, which is necessary for today's complex and ever-evolving revenue models.

See if your healthcare system qualifies for a free denials assessment.

SCHEDULE A CALL

Meet the Sift Experts at
use.sifthealthcare.com/2022-denials-insights

Sales@SiftHealthcare.com
www.SiftHealthcare.com