Alarming Trend: Sharp Increase in Commercial Insurer Claims Denials

By Elizabeth Woodcock, MBA, FACMPE, CPC

Anecdotal evidence about increasing claim denials has been on the medical practice airwaves for months. Whether purposeful or not, commercial health insurers are denying claims at alarmingly high rates. A newly published analysis of claims data revealed that commercial insurers denied a remarkable 15.1% of claims, compared to 3.9% by Medicare. There is limited industry data about the number of denials that are appealed - or, more importantly, the denials that are overturned for payment. The most important issue, however, is what happens at *your* practice. The key is to know about this trend - and to fight for every dollar.

Understand the Opportunity. The term, “silent killer,” is often used in medical settings with reference to diseases that do not present with many symptoms. Medical practices can fall into a silent killer trap with denials, as the symptoms are difficult to see. When a claim is paid by an insurance company, it is rarely paid at the practice’s billed charge due to contractual rates negotiated between the payer and the practice. Therefore, there is an accepted level of non-payment (or contractual write-off). It would be easy to let this

expected write-off amount conceal a denial problem. To monitor this in your practice, routinely run an Unpaid Claims Report or a report for all charges that have $0 payments associated with them. This analysis must be performed at the line-item level. The goal is to understand **why** the services were not paid. Alas, you've opened your denial treasure chest.

Dive Deep. The treasures are waiting, but they will require additional insight to get the gold. Run reports to illuminate the reasons for the denials. This requires an assessment of CARCs (claim adjustment reason codes) and RARCs (remittance advice remark codes) to uncover further detail. You can find a listing of the codes here. Sort your top 10, and then study the details in an organized fashion:

- by service (is there a particular CPT code that is being denied?)
- by provider (is there a particular provider whose services are being denied?)
- by insurer (is there a particular insurer who is denying payment for services?)

Add the date, as there may be denials that cannot be addressed due to timely filing or appeal deadlines. Finally, pull the high dollars to the top, as you'll want to prioritize those.

Attack the Problem. With an understanding of the magnitude of the opportunity, gather resources to address the root cause of the problem. Depending on the size of your practice, consider creating a committee or workgroup that documents a strategy and assigns responsibilities to a team – or it may involve one individual who dedicates a portion of their time to analysis and resolution. Regardless, the key is to establish an action plan with milestones; otherwise, denial management can be overwhelming. Use the top 10 reasons for denials as a guide. For example, if "subscriber not eligible…" is your top denial, decide who can work on the existing denials – and give them step-by-step instructions to work them. This may include, but not be limited to, looking in the guarantor's account for a copy of the insurance card; querying the hospital's database to see if the facility has alternate insurance on file; searching any known beneficiary databases [including Medicaid]; contacting the guarantor by phone; etc. Be sure to prioritize denials by dollars, as it's foolish to spend 30 minutes trying to chase down a $5 denial. Billers are tenacious by nature, so you may need to set guardrails to ensure resources are used wisely.

Recognize that Prevention is the Best Medicine. Perhaps most importantly, it's crucial to embark on a prevention campaign at the same time as you're addressing the existing problem. Denials represent a problem that has already occurred. Take that same top 10 list and determine how to **prevent** the denial from happening in the first place. For example, eligibility-related denials can be improved with a better front-end registration process. This requires leaning into the training, performance expectations, workflow, and tools available to schedulers and receptionists. Furthermore, it requires special attention for out-of-office services, as practices are typically not in control of (or even present for!) the registration process.

Denial management and prevention is work that never stops for a medical practice. It's important to ensure that you do not give insurance companies a reason to deny or delay

payment of your claim. Implementing some basic procedures can help ensure you do not leave precious revenue on the table.

Risk Matters: MATE Act Required Training

By Jeffrey A. Woods, JD

SVMIC is aware of a recent letter sent to all DEA-registered practitioners outlining a new law, referred to as the MATE Act, that requires a **one-time**, eight-hour training requirement for all such practitioners on the treatment and management of patients with opioid or other substance use disorders. Beginning June 27, practitioners must have completed the one-time education requirement before either an initial, or a renewal, DEA registration. Past SVMIC prescribing-specific CME courses count toward satisfying the requirement. SVMIC has created a short video, along with an FAQ page, to cover what is required to satisfy this new law, who is "exempt," and examples of organizations that are qualified to provide the training.

The Importance of Following Up Follow-Up Care

By J. Baugh, JD, CPA

A recurring theme in SVMIC policyholder education is the importance of effective communication between a healthcare provider and a patient. Another recurring theme is the issue of a healthcare provider following up with a patient after the patient has been advised to seek additional testing, treatment, etc. The following closed case is an example in which additional follow up communication would have better served the patient.

Matthew Patterson[1], a 52-year-old male, established as a new patient with Dr. Heather Hoover, an internal medicine physician. Mr. Patterson was taking medication for hypothyroidism and hypertension. His medical history and his physical exam revealed notable findings of colon polyps, lipomas, low back pain with radiculopathy, marginal obstructive sleep apnea, and a prior history of smoking. Dr. Hoover obtained laboratory tests from the patient, and his PSA level was normal at 2.64. He did have elevated lipids for which she started a new medicine, and she recommended weight reduction.

Mr. Patterson's repeat PSA level a couple of years later was 3.35. He was seen by one of

Dr. Hoover's nurse practitioners a few months later for refills of his medication and reevaluation of his hypertension and thyroid. The lab tests returned with a significant elevation in his PSA level at 5.34. There was a note in the chart from the nurse practitioner to a medical assistant to call Mr. Patterson to "advise lab results back." The medical assistant was instructed to tell him that he needed to follow up with Dr. Hoover in six months to retest his PSA level because of the elevated results. The nurse practitioner also conveyed to the medical assistant several questions to ask Mr. Patterson about possible symptoms of prostatitis and/or a UTI and instructed the medical assistant to call in an antibiotic for presumptive infection. There is a note in the chart that this information was communicated successfully to Mr. Patterson, including being told to return for a repeat PSA level.

Mr. Patterson did not return to Dr. Hoover's office until a year later at which time he saw another of Dr. Hoover's nurse practitioners for medicine refills. The nurse practitioner's note listed the previously elevated PSA level, but there was no evidence that she ordered a repeat level, nor is the elevated PSA level mentioned in either her list of his primary problems or in the plans she outlined for his care. Like his previous visit, he denied urinary symptoms. The nurse practitioner attempted to obtain lab results, but Mr. Patterson was not fasting and was moving to a different city the following week. He told her he could not return for labs, so she restricted his medicine refills to three months. There was no evidence of a conversation with Mr. Patterson about the need to obtain updated PSA test results.

Mr. Patterson had a repeat PSA test about three months after his last visit with Dr. Hoover's nurse practitioner upon changing his healthcare to a new physician after his move. His PSA level was 13, a rise of 8 points over a 14-month period. The record indicates he had a prostate exam within the previous year but that was not the case. Neither Dr. Hoover nor any of her nurse practitioners performed a prostate exam during any of their visits. A urinalysis was normal, and the remainder of his lab values were either normal or of minimal importance.

Mr. Patterson was referred to and seen by a urologist. Mr. Patterson had minimal symptoms of urinary obstruction. His exam revealed a normal sized prostate without nodules, masses, or other obvious pathology. In the intervening month, his PSA level had risen to 17.06, a 4-point increase. A biopsy was done about a month later, and his prostate cancer was initially graded as a Gleason score of 7. Because of the rapid progression of the PSA levels, the patient's age, and his Gleason score, Mr. Patterson was deemed to be high risk and scheduled for a metastatic work-up. The urologist initially sought to perform a robotic prostatectomy, but when the metastatic work-up disclosed a lesion in the first lumbar vertebra and pelvic adenopathy, he waited until the work-up could document the extent and likelihood of these findings being associated with the prostate cancer. He also submitted the pathology specimens to the Johns Hopkins pathology department, and this resulted in upgrading the Gleason score to 8. The L1 biopsy result was positive for cancer. The enlarged nodes were assumed to also be positive, so his option for a robotic prostatectomy as a curative procedure was downgraded to palliative.

However, the patient responded very well to the treatment prescribed, and the pelvic nodes and the L1 metastasis decreased remarkably. His PSA level also decreased to a nearly undetectable level of 0.10. However, the treating physician told Mr. Patterson that there was no cure, and that he would eventually stop responding to the hormone therapy that was being used to treat him.

A lawsuit was filed against Dr. Hoover, the two nurse practitioners who treated Mr. Patterson, and the corporate entity that employed Dr. Hoover and the nurse practitioners. Mr. Patterson alleged that Dr. Hoover and the nurse practitioners were negligent in not informing him about his elevated PSA levels, not advising him to have more frequent PSA tests, and not referring him to a urologist. The defendants relied on the fact that Mr. Patterson was informed of his PSA level of 5.34 and chose not to return to Dr. Hoover's office for a year, despite her recommendation that he return in six months for a repeat PSA test. Although it was noted in the chart that the patient was called and a message was left about the PSA level and the need to return to the office for repeat PSA testing, such was denied by Mr. Patterson during his deposition. A factor that was considered in deciding whether to settle this case was the fact that a message was left on the patient's voicemail rather than actually speaking with the patient. A second issue regarding the phone call was whether the clinic had an obligation to follow up with the patient when he didn't return to the clinic as instructed. A third issue regarding the phone call was whether a nurse practitioner should have asked a medical assistant to place the call, or whether the nurse practitioner should have placed the call. A final issue was the fact that when the patient finally returned to the clinic and declined further testing because he was moving to another city the following week, there was no evidence that the nurse practitioner discussed with him the importance of a follow-up PSA test. As is often the case, each of these issues alone might have been defensible, but having to address all four made the case difficult to defend.

Another factor considered in this case was the patient's responsibility to follow up on the advice to return to the clinic for follow-up PSA testing in six months. The defense could have argued that once the patient was told to return to the clinic, it then became the patient's obligation to follow the clinic's advice. However, the patient could have responded that, if additional PSA testing were that important, it was incumbent upon the clinic to follow up with the patient and ask why he did not return to the clinic as instructed and that the failure to do so led the patient to the conclusion that the instruction to return wasn't all that important . In situations such as this, it is very difficult to predict how a jury would answer this question if this case were to go to trial.

A final issue that was considered in whether to settle this case was the concern that Dr. Hoover might have been critical of the nurse practitioners and of the clinic's systems had this case gone to trial. If a jury hears that a defendant has been critical of another defendant's medical care it usually benefits the plaintiff, and a jury may decide that at least one of the defendants must have been at fault in the case.

While this case was pending, the plaintiff voluntarily dismissed Dr. Hoover and the two

nurse practitioners, leaving the corporate entity as the only defendant. Mediation was held, and Mr. Patterson and the corporate entity were able to reach a resolution of the case.

The key takeaway from this closed case is that communication between a healthcare provider and a patient is extremely important, especially when the communication is about follow-up care. It might be easy to think that once a patient has been told about follow-up care then the responsibility shifts to the patient, but it may be safer to assume that if follow-up care is necessary, the healthcare provider should take extra steps to try to ensure the patient receives that care and to document those extra steps in the medical record. As a healthcare provider, you have a better understanding of the consequences of various treatment options as well as delays in treatment, whereas patients may not grasp the significance of such. Not only is this important to good patient care, but it is beneficial to the healthcare provider's defense should there be a trial.

[1] Names have been changed.
