experian health

IS TECHNOLOGY THE ANSWER TO THE WORSENING DENIALS PROBLEM?

Industry survey shows nearly two-thirds of providers audited claims technologies as denials increased during the pandemic

healthleaders

Is Technology the Answer to the Worsening Denials Problem?

Industry survey shows nearly two-thirds of providers audited claims technologies as denials increased during the pandemic

ROB STUCKER

Senior Vice President
Product Management
Experian Health

While denials are not a new headache, they are a problem that worsened throughout the pandemic for most hospitals and health systems. A recent Experian Health–sponsored survey by HealthLeaders reveals denials increased at 80% of healthcare organizations since 2019, with 43% experiencing a 10% to more than 20% increase. Thirty percent of organizations say 10% to more than 15% of claims lead to a denial.

The survey offers insights from 100 leaders across the healthcare ecosystem, including health systems, hospitals, and physician organizations, who share top reasons for denials and perspectives on technology solutions—nearly two-thirds of respondents say they are monitoring claims technology.

"The answers to this issue aren't simple, but we believe technology can address many of the primary causes of denials."

—Rob Stucker, senior vice president, product management, Experian Health

"The denial rate is concerning when looking at historical averages," says Rob Stucker, senior vice president of product management at Experian Health. "Ten percent is still a very large number for denials and a steep increase from the 2% to 5% bracket considered acceptable just a few years ago. The answers to this issue aren't simple, but we believe technology can address many of the primary causes of denials."

Why are denials still problematic?

Providers have become increasingly concerned over the reimbursement environment, particularly the rise in denials, which they attribute to numerous factors. According to respondents, the top three reasons for denials are eligibility issues, such as services not covered (56%), coding errors (54%), and incorrect modifiers (35%).

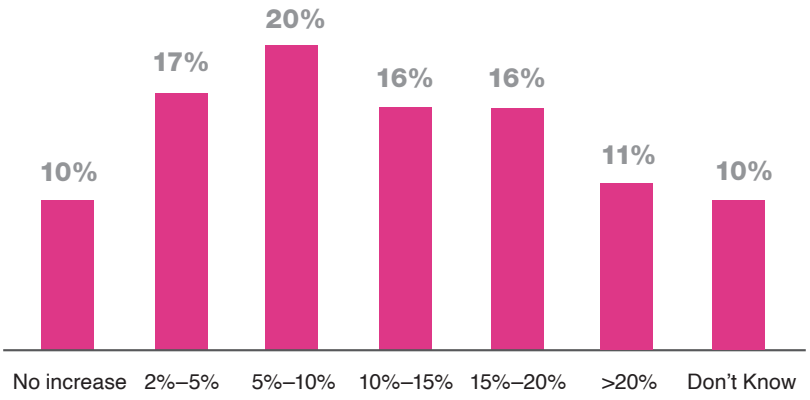
Stucker says eligibility has been the leading cause of claims denials for many years. However, the high number of coding denials also points to a shift. "While eligibility is still a top issue, the complicated rule change from ICD-9 to ICD-10, which resulted in a lot more specific coding requirements, is still very much a cause for concern for healthcare

organizations," he says. "More scrutiny occurs every time there are new requirements, and claims get denied."

He adds that payers are also changing the rules more frequently without prior notification, causing many downstream issues. "For example, a payer may change how they are adjudicating a specific service, and the provider won't realize it until they start receiving a flood of denials, forcing them to play catch-up constantly."

INCREASE IN DENIALS SINCE 2019

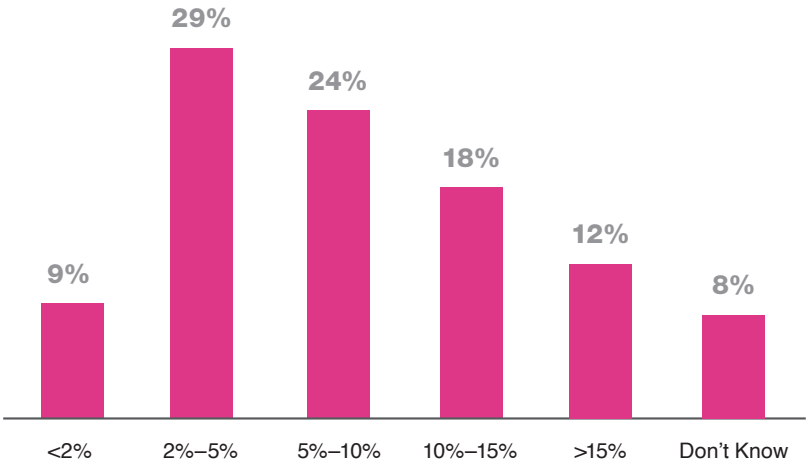
How much, if any, have your denials increased since 2019?



BASE: 100

PERCENTAGE OF CLAIM DENIALS

What percentage of your current claims result in denials?



BASE: 100

Beyond denial percentages, providers must address preventable vs. non-preventable denials, which can have a more significant impact, says Stucker. "There are more than 800 ANSI codes that payers can use to associate with why they're denying a claim." Out of that number, about 100 represent denials due to preventable factors, including incorrect modifiers, late filings, or lack of authorization. "Those are the things on which providers should also focus."

The benefits of technology

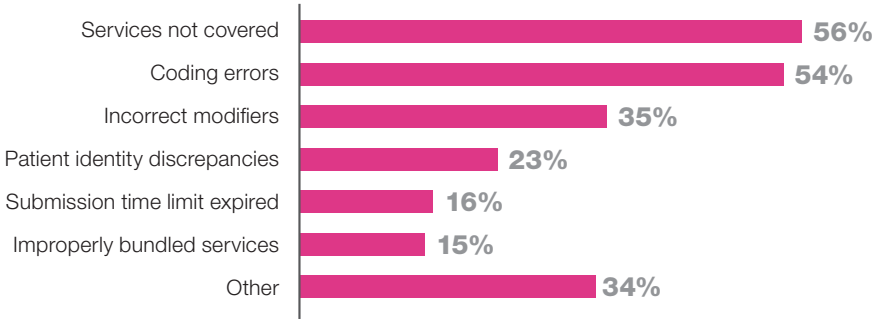
Interestingly, 10% of respondents saw no increase in denials, which Stucker attributes to investment in automation and training. "Technology can do much to prevent or reduce a denial when applied correctly," he says. "The best way to reduce [the chances of] a denial is to make sure the claim goes out the door correctly, and it starts with your claims vendor." Stucker says claims vendors should have detailed editing libraries to address the issues cited by respondents, such as coding errors and incorrect modifiers. Automated software can also handle pre-claim edits when the claim is still at the encounter stage. "Pre-editor automation checks and validates that codes are correct and stops coding errors before the claim

gets created in the patient accounting system," he says, adding it is critical to fix as many problems upstream as possible.

"The final claim check before the claim goes out the door should be a safety-net process only. It shouldn't be the primary place where you're stopping things," says Stucker, adding that organizations must carefully monitor technology to ensure it is working correctly and providing value. "When determining eligibility, for example, providers often make the mistake of thinking automation will solve all of their problems," he says. "Although automating eligibility saves tremendous time, processes must still be in place to ensure the team running the automation receives proper training." For instance, incorrectly entering a patient's name will lead to a denial. To that point, 23% of respondents say patient identity discrepancies are a top denial reason. "Automate, train, and then review because this is not a static environment—the rules change all the time," says Stucker.

TOP REASONS FOR DENIALS

What are the top reasons for denials?



BASE: 100 (SELECT ALL THAT APPLY)

AUTOMATION SOLUTIONS AND/OR ARTIFICIAL INTELLIGENCE SOLUTIONS

Have you considered automation solutions and/or artificial intelligence (RPA, ML, AI) to help with denials?

	Have not considered this technology	Have considered this technology	Are currently using this technology
Robotic process automation (RPA)	63%	32%	5%
Machine learning (ML)	61%	33%	6%
Artificial intelligence (AI)	48%	45%	7%

BASE: 100

Reaching the tipping point of technology adoption

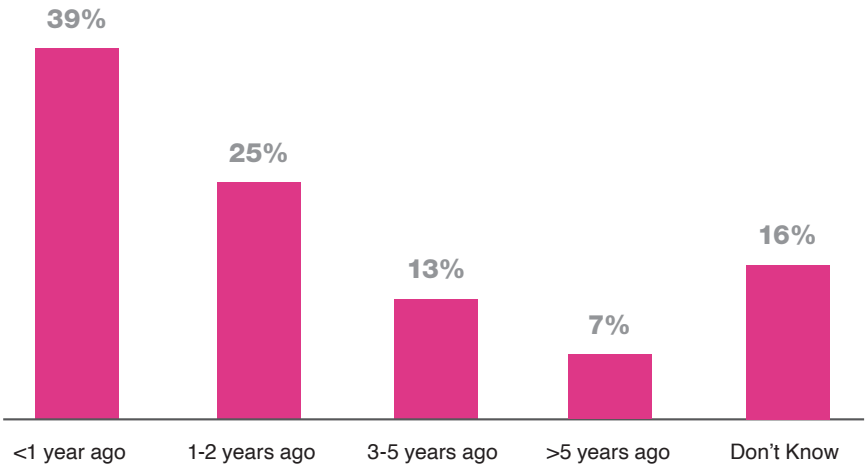
Survey respondents stayed on top of revenue cycle technology assessments even during the pandemic, underscoring the importance of claims technologies in denial prevention. Over one-third say they evaluated their claims technology in the last year (39%), while 25% did so in the previous one or two years. "Provider organizations are responding to changes during the pandemic and new legislation such as the No Surprises Act," notes Stucker.

Although claims technology solutions are robust and widely used to tackle denials, only 5%–7% of survey respondents say they use AI, machine learning, and robotic process automation (RPA) in this area. However, one-third to nearly half have considered using these technologies. This lackluster response is puzzling, given current challenges around denials, reimbursement, staffing shortages, and costs.

Stucker says most organizations have been using RPA—which applies repetitive programming processes to

MOST RECENT EVALUATION OF CLAIMS TECHNOLOGY

When was the last time you evaluated your claims technology?



BASE: 100

automate tasks—for many years but may not realize it. "Still, as a whole, our industry has been slower than others to adopt AI and machine learning," he observes.

At the same time, Stucker says vendors have recently made many promises on what they could achieve with AI and machine learning that went unfulfilled. "It has made the industry a little more cautious." Also, employee pushback is natural when introducing new technology, he adds. "Employees are looking to protect their jobs. But it's important to remember that AI and other technologies allow your existing headcount to be much more productive without adding more staff."

What will be the jumping-off point that takes providers beyond evaluation to adopt new technology solutions to improve claims management? "Vendors have to deliver on the promises they have made, including that AI solutions can predict a claim will eventually be denied even after passing all vendor edits and meeting all documented requirements for positive adjudication," says Stucker.

Equally important, he adds, is that providers be willing to participate in the learning process. "At Experian Health, we initially work with one or two facilities on proof of concept. Then, over time we bring in more organizations as true beta sites before we roll out a new product," says Stucker. "Taking the time to go through the development process requires discipline. The clients we work with are true partners who are integral to product design."

ABOUT EXPERIAN:

Experian Health partners with over 63 percent of US hospitals and 7,700+ other risk bearing entities to provide connect and simplifying healthcare for all. With over 25+ years of healthcare experience we're prepared to bring your organization to the next level in revenue cycle management, identity management, patient experience and care management.

experian health