REVENUE CYCLE MANAGEMENT Q&A

Decreasing Denials and Rejections Through Your Urgent Care Operating Model

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A wise person once said, "If a claim is rejected or denied, the energy to get it paid is five times the energy if it went through as a clean claim." Maybe it is only four times or three times the work, but the point is that we should all do everything we can to avoid rejections and denials!

Unlike more complicated specialties subject to complicated coding, authorization, and other factors, in an urgent care setting, the primary cause of downstream work is errors at the front desk during the patient intake process. In fact, over one third of all urgent care denials are eligibility-related, and for many clinics, that ratio is over 50%. Below is a summary of the primary drivers of urgent care denials.

What Is Driving Our Denials?

- Eligibility 34%
- Medical records requests 21%
- Coding 13%
- Credentialing 8%
- OON/No auth 4%
- Other 20%

Not only are eligibility-related rejections and denials the most common, but they are also the most avoidable with strong processes and accurate information available to the front desk staff. Before we explore the recommendations into the avoidance, however, it's important to understand the potential ramifications of ignoring the problem.

According to the Medical Group Management Association (MGMA), the cost of reworking a claim is $25 on average. On the surface, this seems awfully high. It's not as though we are paying someone $25 per hour to work rejections and denials and they only work one claim per hour. The reason this cost is so substantial is because once a claim is rejected or denied, the likelihood of it converting to bad debt increases exponentially.

This can be a compounding problem for those clinics with a higher propensity to create eligibility errors, as increased volumes of downstream work stretch the turnaround time of that work, and timely filing issues therefore present themselves.

An average ratio of rejections + denials is around 10%. Clinics at that average, assuming the MGMA estimated cost of $25 for rework, are potentially adding $2.50 of cost to their business for every patient walking through the door. Whether you consider that in terms of your net reimbursement per visit, patient volume, or both, that extrapolation can be staggering.

So, what can be done to make sure your practice is below that 10% average and to limit the ramifications to your bottom line? The answers are simple, but not necessarily easy to execute.

First, make sure front desk staff develop habits to ensure the basic blocking and tackling happens, without exception. Primarily, that means utilization of your practice management system's real-time eligibility verification module on 100% of applicable visits.

Note, however, that it is not enough to run the eligibility; staff must be versed and educated well enough to know where the potential pitfalls lie within those messages.

The chief example of this is Medicaid. In many states, a majority of Medicaid patients are covered by a Medicaid Managed Care Organization (MCO) as opposed to straight Medicaid. If you are in one of those states, your real-time eligibility message may indicate the patient is active with Medicaid, but that doesn't tell the whole story. It is necessary to know which Medicaid payer covers the patient, whether the ID is the same as their straight Medicaid ID or not, and whether there are any limitations

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within that coverage. Oftentimes, depending on how comprehensive the payer's eligibility responses are, front desk staff may need to utilize a payer portal to obtain information necessary for a clean registration.

Clinics that have been successful in this regard have ensured their staff have current information at their fingertips, and update that information regularly. What we typically see in medical offices at the front desk is a disorganized catalogue of printouts and sticky notes containing all these rules. Those tend to go overlooked and ignored. Consider building an intranet site with information on what is required specific to your major payers and ensure that is updated regularly. Include guidance on your internal policies for which the front desk staff are responsible. These might include, but are not limited to, your time-of-service collection policies for various types of visits, your credit card on-file policy, and what is required for school or sports physicals, just to name a few.

As mentioned above, implementing this toolset is not a low lift. Those that have been successful with it, though, have dedicated resources to its maintenance and have seen an undeniable return on investment, even during the peak volume surges of the pandemic when adherence to standard protocol was at its most difficult.

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Finally, building and maintaining resources to ensure proper registration, and therefore optimize clean claims, is just half of the equation. Success will rely on proper utilization of the tools, so resources must be dedicated to auditing the work that gets performed at registration, with necessary actions and training dictated by those audits.

The bottom line is that by eliminating all avoidable denials and by taking the extra minute to submit clean claims, you can save yourself five times the energy and make your RCM life a little easier. ■

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