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KODIAK RCA BENCHMARKING ANALYSIS

Necessity is the mother of claim denials

Increasing payor claim denials for prior authorization and precertification violations are creating significant financial headwinds for provider organizations. What can providers do to push back?

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Introduction

When patients are sick or injured, they feel a medical necessity to go to the doctor, hospital emergency room, or other setting for care. Doctors, nurses, other clinicians, and staff who see those patients sense the medical necessity and feel a professional duty to help them regardless of their health insurance status. In that moment, patients expect—and providers deliver—the same level of care.

There typically is a third party in this scenario who sits between the patient and the provider: The payor. The payor analyzes the medical necessity to pay for that care or the level at which it was provided to the patient.

This quarterly key performance indicator (KPI) revenue cycle benchmarking report from Kodiak Solutions digs into the rise in prior authorization and precertification claim denials for medical necessity by payors and how that trend is affecting providers' financial health. The report also offers ideas about how providers can push back against this financial threat to them and clinical threat to their patients.

The claims data used in this exclusive analysis comes from the Kodiak Revenue Cycle Analytics (RCA) platform used by more than 1,850 hospitals and 250,000 physicians to manage their net revenue and monitor their revenue cycle performance. Kodiak weighs the averages and uses raw benchmarking data to make the KPI calculations.

Download the previous Kodiak quarterly KPI benchmarking reports

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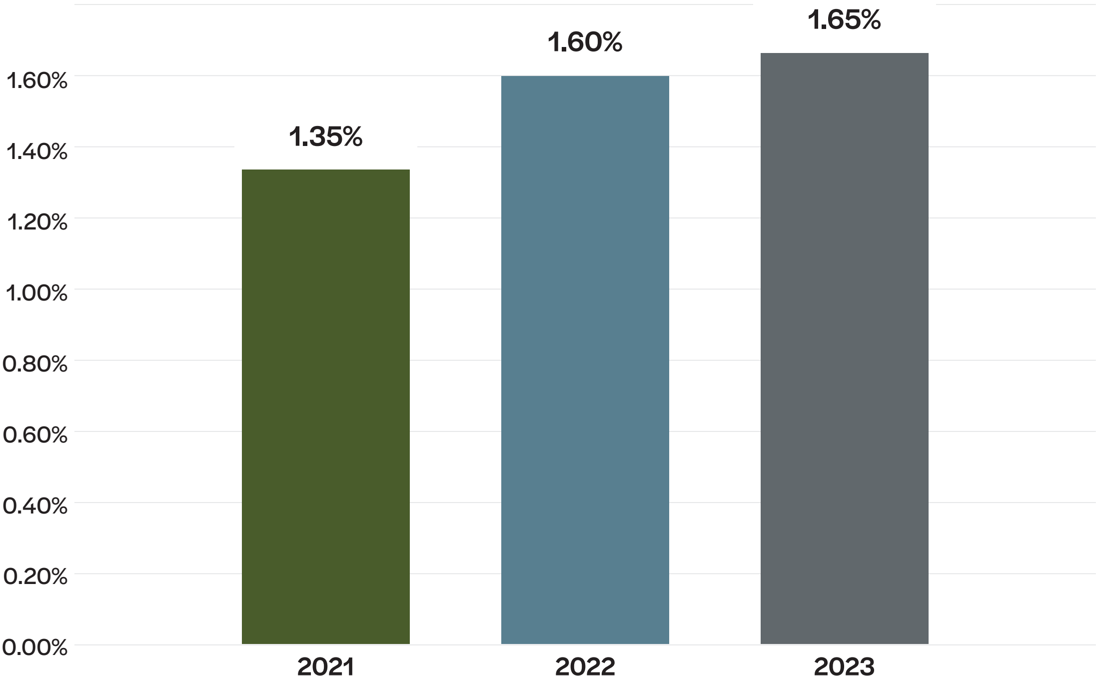
Prior authorization and precertification claims denial rates are rising

Prior authorization and precertification (prior auth/precert) claim denials by payors are a type of initial denial for determined medical necessity. When a payor initially denies a claim for payment from a provider for prior auth/precert reasons, the payor saying that a specific episode of care didn't meet its prior auth/precert criteria, standards, or payment rules.

The prior auth/precert claim denial rate, expressed as a percentage of all claim dollars billed, has risen in each of the past two years.



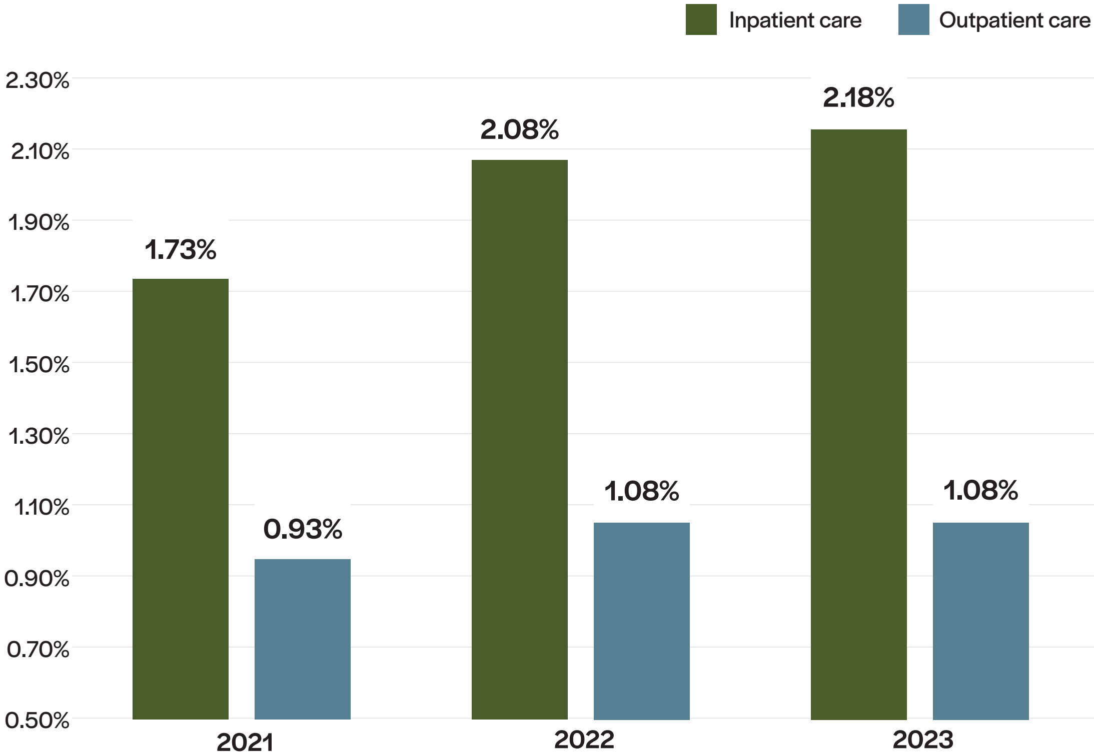
The climb in the prior auth/precert claim denial rate to 1.65% last year from 1.35% in 2021 represents a 22% increase in the rate. Preliminary data for 2024 suggests that the climb might be leveling off but not returning to 2021 levels.

When we dig deeper into the Kodiak RCA data, and we separate prior auth/precert claim denial rates by inpatient care and outpatient care, we can see that the inpatient prior auth/precert claim denial rate is driving the overall increase.

The outpatient prior auth/precert claim denial rate rose 16% to 1.08% in 2023 from 0.93% in 2021, while the inpatient prior auth/precert claims denial rate rose an eye-opening 26% to 2.18% from 1.73% over the same time period.

Again, preliminary Kodiak RCA data shows that both inpatient and outpatient prior auth/precert denial rates may be ebbing this year but not returning to 2021 levels or below.

Chart 2: Prior authorization and precertification denials by inpatient and outpatient care



Source: Kodiak RCA

Level of care is in the eyes of the payor, not the provider or patient

Prior auth/precert claim denials are primarily related to the level of care required to treat a patient appropriately given their medical condition and status. However, level of care is a subjective determination made by the payor, not the provider. Doctors, nurses, other clinicians, and staff administer the appropriate care to each patient, regardless of the patient's insurance status or benefits. Then, the payor decides whether the level of care and the services performed were medically necessary for payment purposes.

If the payor determines that the level of care and the services performed were appropriate, the payor would pay the claim. If the payor decides that services weren't appropriate, the payor will initially deny the claim for prior auth/precert reasons, forcing the provider to appeal the denial.

Many of these denials are based on the payor's criteria for observational versus inpatient care. Based on the patient's medical condition, should a provider observe the patient and discharge them to their home? Or should the provider observe the patient and then admit them? If a provider does one versus the other, and the payor disagrees, here comes the prior auth/precert claim denial.

Payors generally pay more for inpatient stays than for observational stays. This choice also has ramifications for patients' out-of-pocket financial responsibilities, providers' patient collection rates, and providers' bad debt write-offs. Determining the level of care is a slippery slope from a revenue cycle perspective.

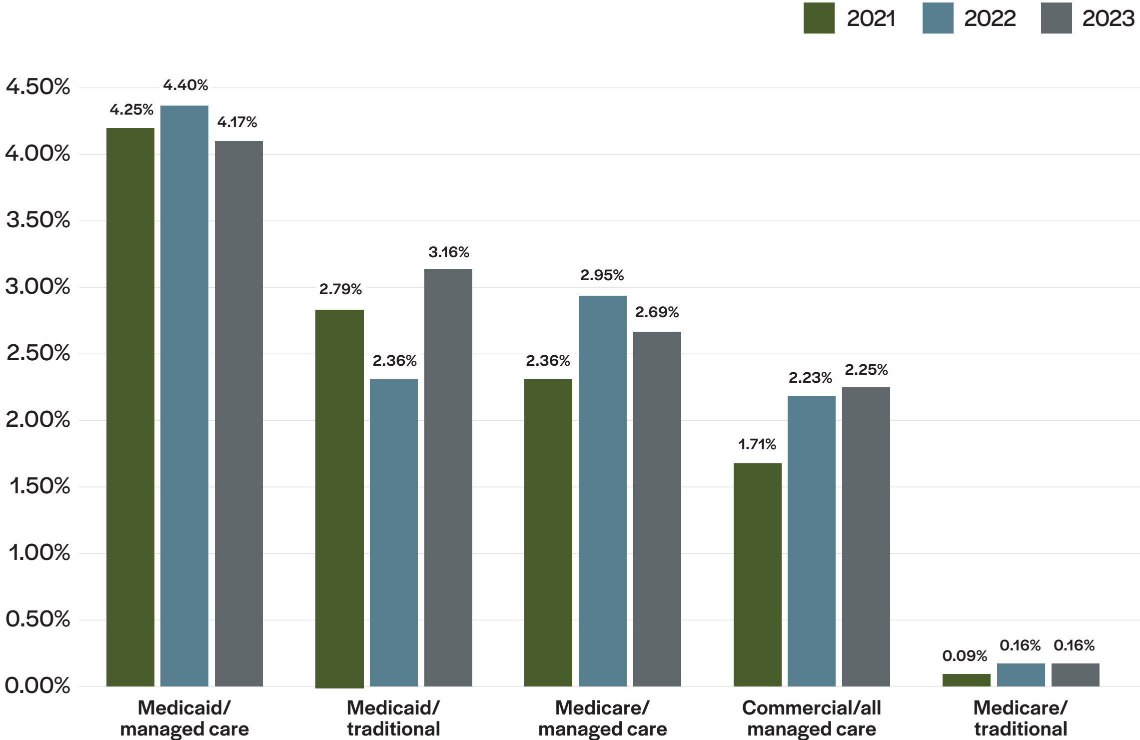
This is a peculiar payment trap for providers because each payor has its own criteria for determining observational or inpatient status. Further, commercial payors don't necessarily follow Medicare's two-midnight rule for making determinations. Essentially, if the patient is sick enough to stay in the hospital for 48 hours, Medicare considers that patient to be an inpatient.

Prior auth/precert denials vary by payor category

If all payors used consistent criteria for making prior auth/precert claim denials, the denial rates would be similar across payor categories. That would make it easier for providers to learn from those denials, reduce their overall initial denial rates and spend fewer resources appealing prior auth/precert denials because of conflicting and ever-changing payment criteria.

Again, we dug into the data to find out what's happening.

Chart 3: Prior authorization and precertification inpatient claim denial rate by payor category



Source: Kodiak RCA

The data showed, as displayed in Chart 3, that different payor categories have different prior auth/precert inpatient claim denial rates and have had for the past three years. Assuming that patients' medical conditions and severity of illness are generally the same across payor types and that providers generally diagnose and treat them the same way, the data suggests that payors are using different criteria to make prior auth/precert claims determinations.

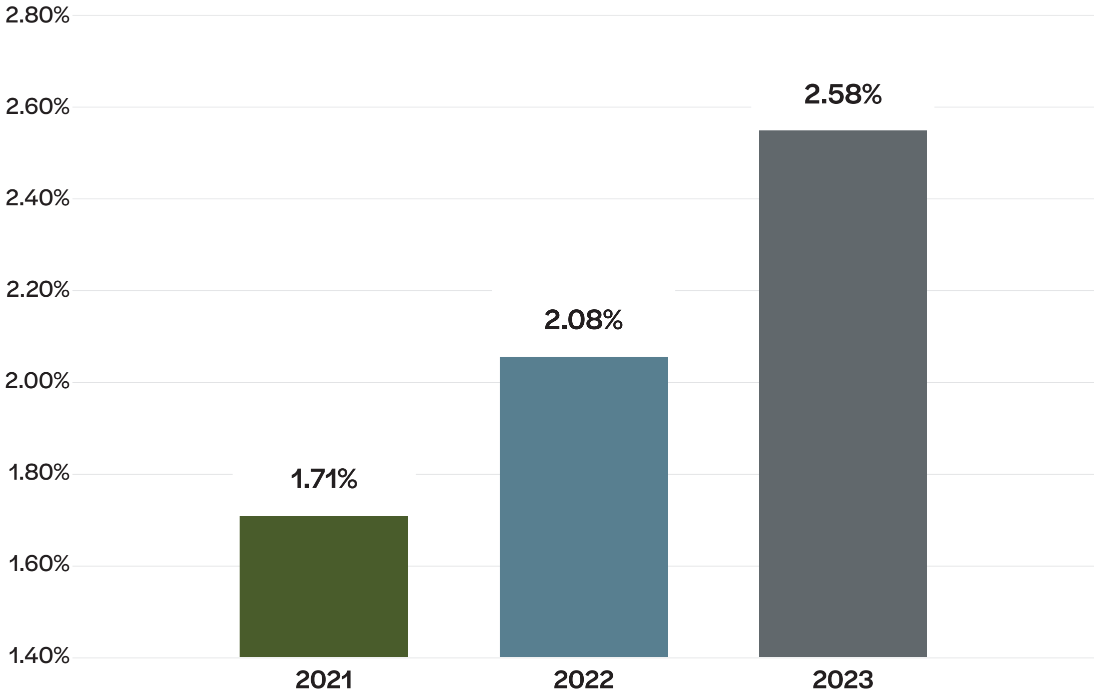
The criteria inconsistencies place an undue and costly administrative claim burden on hospitals, health systems, and medical practices in the following ways:

- The wide range in prior auth/precert claim denial rates by payor type suggests that many of these denials are unnecessary, if not arbitrary, and artificially inflate providers' appeal costs.
- With little standardization in the claim appeals process across payors, providers must be well-versed in different appeals processes, adding to their costly administrative burden.
- Even when an established process exists, many of these processes are overly manual and use outdated technologies (for example, fax machines) which routinely create situations requiring rework.

Converting prior auth/precert claim denials into real money

Although providers reverse many prior auth/precert claim denials on appeal, prior auth/precert claim denials are a major contributor to providers' increasing final claim denial rate. Final denials are unpaid claims that providers are expected to write off as bad debt.

Chart 4 displays a 51% jump in the final inpatient claim denial rate over the past three years.



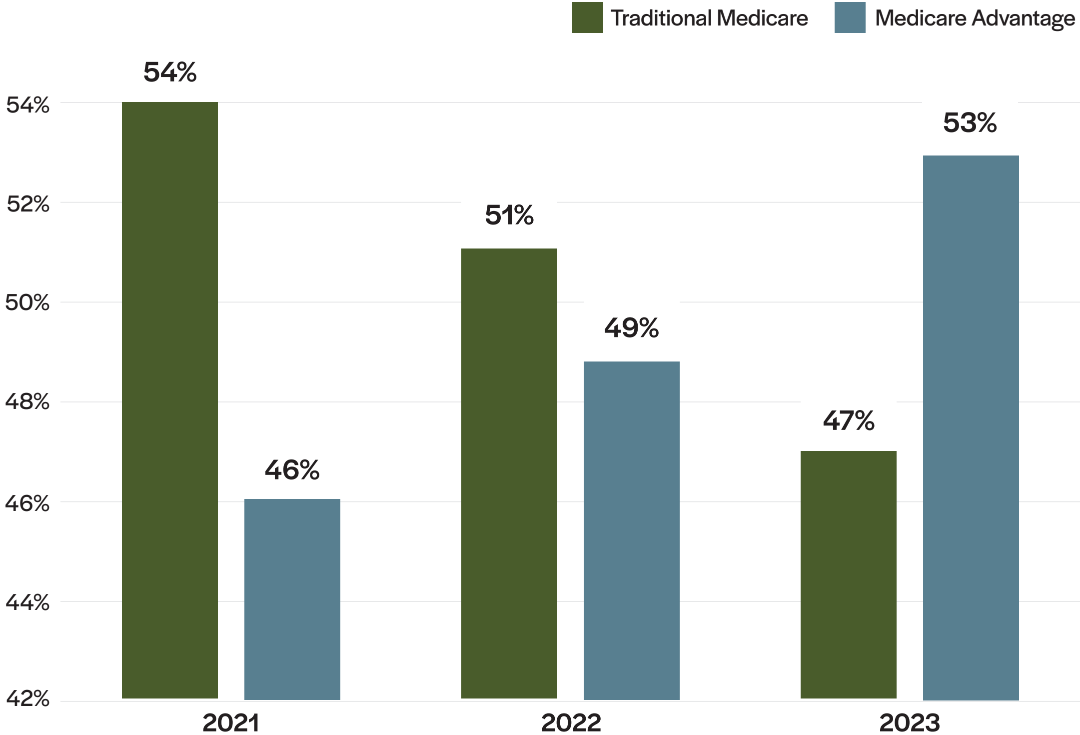
The final inpatient claim denial rate is an expression of the percentage of the inpatient claim dollar value lost to final denials. The 51% increase in the final inpatient claim denial rate to 2.58% in 2023 from 1.71% in 2021 equates to nearly $1.2 billion in lost revenue. Those are dollars providers could have reinvested in patient care. That's on top of the money providers spend appealing prior auth/precert claim denials.

The shift to Medicare Advantage could spell more trouble

Adding salt to the financial wound is the fact that more Medicare beneficiaries are enrolling in Medicare Advantage (MA) plans than in traditional Medicare. In fact, about 33 million beneficiaries, or about half of all beneficiaries, are enrolled in MA plans this year, according to a recent analysis of Medicare data by Chartis, the Chicago-based healthcare management consulting firm.

The trend in total Medicare revenue generated by provider users of Kodiak RCA reflects the enrollment shift to MA from traditional Medicare.

Chart 5: Medicare Advantage revenue eclipses traditional Medicare revenue



Source: Kodiak RCA

Last year, MA revenue represented 53% of total Medicare claims paid by providers on the Kodiak RCA platform, effectively flipping the script with traditional Medicare in just two years.

Why is that flip important? The change puts more Medicare revenue at risk from the higher prior auth/precert claim denial rates from MA plans. That revenue risk is in addition to the higher expenses that providers can incur to appeal those denials by MA plans. This financial situation could only get worse if more eligible patients continue to select MA plans over traditional Medicare in the years ahead.

Pushing back against prior auth/precert claim denials

Hospitals, health systems, and medical practices can take a proactive approach to reversing the tide of increasing prior auth/precert claim denials. Following are three affirmative actions provider organizations can take now.

1. Confirm that revenue cycle and clinical teams align on the level of care assigned to a patient. Working together helps prevent or reduce the chances of a prior auth/precert claim denial and builds a strong appeals approach when necessary.
2. Understand the effect prior auth/precert claim denials have on the organization's financial performance at the care setting level and at the payor level. Then, compare the claims experience with that of peer organizations in the market.
3. Communicate trends in payors' behavior with advocacy partners, including both state and national hospital associations and professional medical societies.

Remember: Medical necessity might be optional for payors, but it's not for provider organizations or their patients.

Learn more

For more information on the Kodiak RCA benchmarking program, visit the business intelligence and analytics section of our website or contact:

Ken Ruiz
Chief Revenue Officer
317-706-2765
ken.ruiz@kodiaksolutions.io

Colleen Hall
Senior Vice President, Revenue Cycle
615-515-3813
colleen.hall@kodiaksolutions.io

Matt Szaflarski
Director, Revenue Cycle
630-586-5229
matt.szaflarski@kodiaksolutions.io

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