DENIALS AND APPEALS SURVEY

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INTRODUCTION

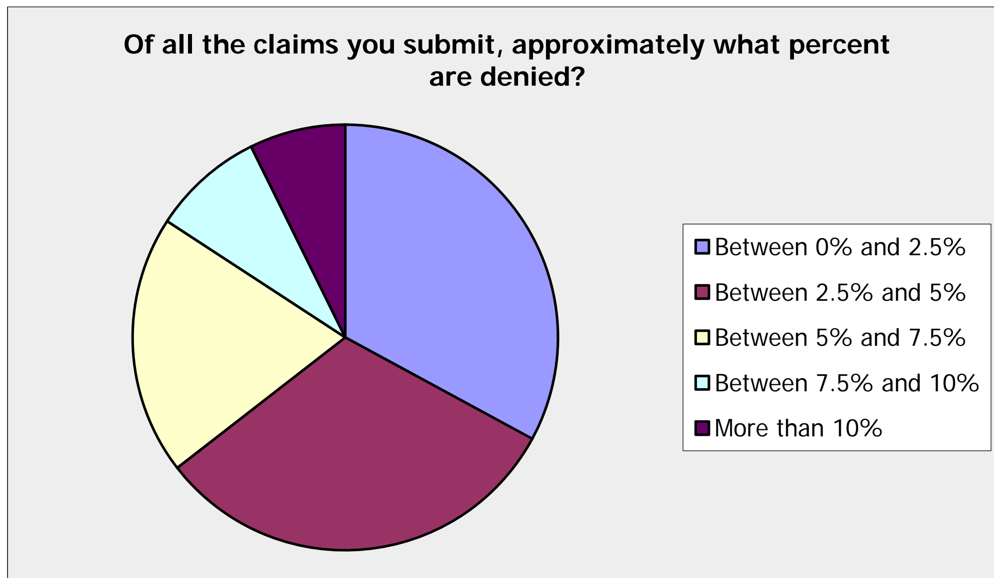
This survey was initiated on February 17, 2010 and closed on March 5, 2010. Responses were handled via SurveyMonkey.com, which prohibits more than one response per IP address. While this does not prevent respondents from taking the survey more than once, it does discourage this practice since it requires that they use a different computer each time.

The survey consisted of five substantive questions regarding denials and appeals and two questions focused on demographics (state and specialty). In all, 234 individual responses were logged and where questions were skipped, this is noted in the results for that question. Due to a number of biases (self-selection, volunteer, etc.), I do not consider this survey to be statistically valid, however, there is a big difference between statistical significance and practical significance and based on the responses, I am confident that the results of this survey convey a very significant message about our health care claims process.

RESULTS

Question 1 asked about the number of claims filed per month. The purpose was to establish the overall diversity of respondents to the survey. Answers ranged from 30 per month to 600,000 per month with some respondents using textual answers (i.e., "thousands"). Allowing textual responses was likely a mistake as it prohibited me from being able to calculate point estimates and variability within the sample.

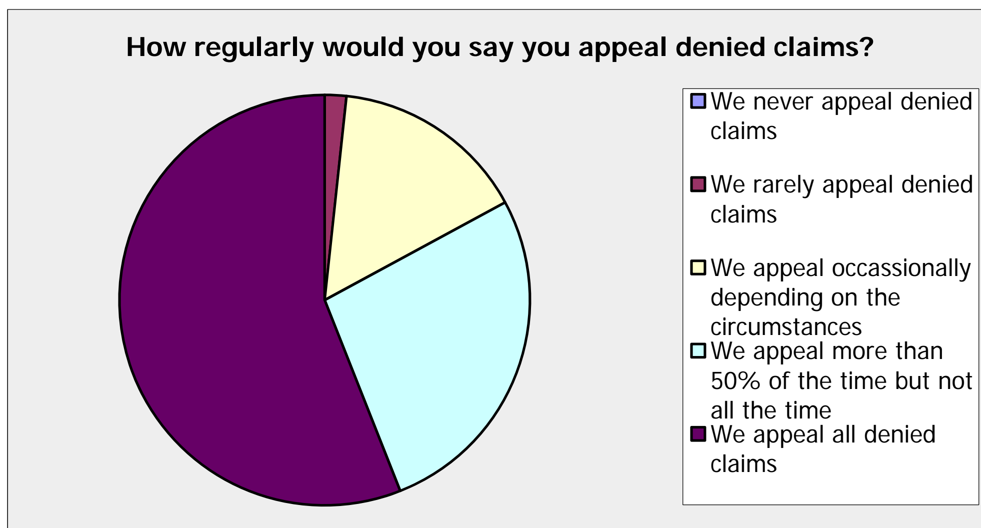
Question 2 asked about the number of denials as a percent of claims submitted.



Using a proportion distribution calculation and assigning the mid-point for each of the listed ranges, we estimate that approximately 3.8% of all claims submitted by practices responding to this survey were defined as denials. This is very close to the overall results of 3.9% of denials reported in the AMA's 2009 National Health Insurance Report Card analysis (http://www.ama-assn.org/ama1/pub/upload/mm/368/2009-nhirc-long.pdf).

It is estimated that there are some 4.5 billion physician claims filed each year in this county. Using the above calculation, we estimate that approximately 181 million result in a denial of payment.

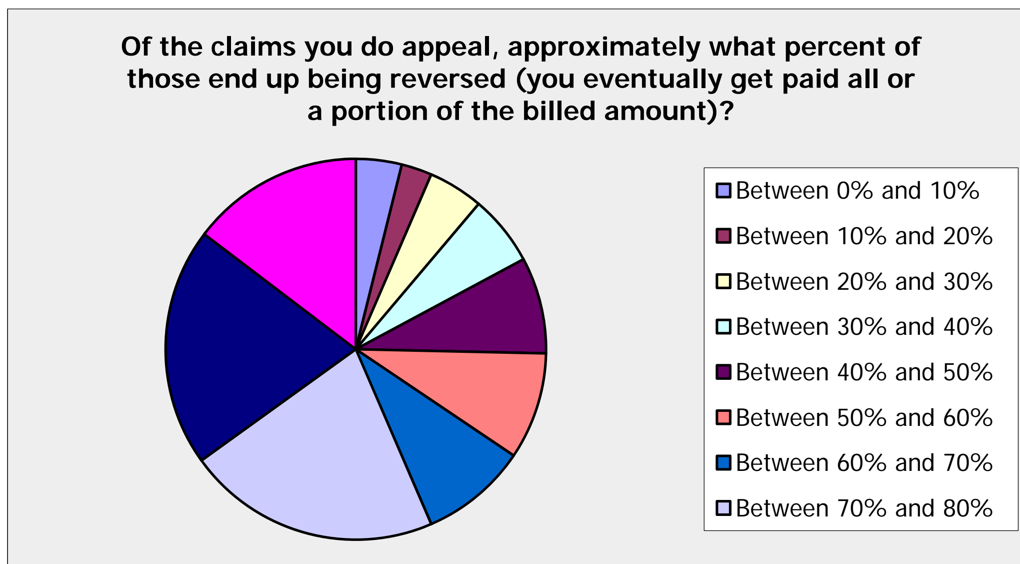
Question 3 asked respondents to estimate how often they appeal denied claims. It is important to note that some claims are denied legitimately while others are not. Some denials are due to errors and/or omissions from the provider while others may be improperly initiated by the payer. This survey did not attempt to differentiate between the two and the idea of what constituted an appealable denial was left up the respondent's own definition.



131 of total respondents completed one of the five responses listed for the question. 21 used the 'other' field, which allowed for a textual response. The overwhelming majority of respondents reported that they appeal all denied claims (56%) while 83% stated that they appeal more than 50% of denied claims. Of those that used the 'other' field, the majority stipulated that they review the denial first and only appeal if they believe that the denial was in error. Several responded that the overwhelming majority of denials fell into this category.

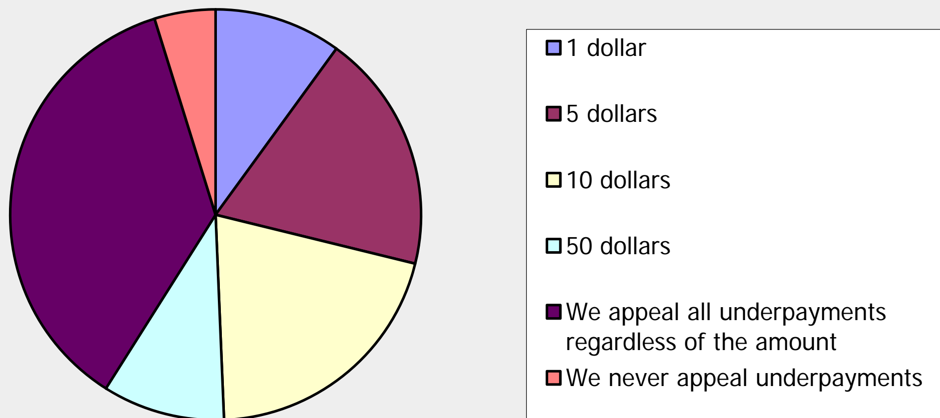
Question 4 asked those that reported appealing claims to respond with the percent of those that were ultimately reversed on appeal. Note that we did not define the term 'reversed' and depended upon the respondent to interpret the question.

I broke down the response categories into deciles and asked respondents to report to the closest range. I recognize that each of the highest category values overlapped with the next category's lowest values, however, we were looking for a range value rather than a point estimate.



The largest response range was 'Between 70% and 80%', with 21.6% of the 232 respondents reporting this as the range of reversals. Using a proportion distribution calculation of the midpoint for each range category, we estimate that 65.7% of all denials are reversed on appeal. Of the estimated 191 million claims denied each year, this would translate to 126 million reversed on appeal. Overall, 52% of respondents reported a reversal rate of greater than 70%.

Question 5 asked about appeal thresholds in dollars and it is noted that the question may have created some confusion based on the way that it was worded in the survey. We asked about the dollar amount threshold to appeal a claim and prompted for an answer with: "**I won't appeal an underpaid claim if the underpayment is less than:**" while I should have asked the question such that the prompt would have been "**more than".** As such, I am not confident in the results of this question. I have, however, provided the results for review.



In essence, 10% said that it had to be more than 1 dollar, 18.8% said more than 5 dollars, 20.5% said more than 10 dollars and 9.6% said more than 50 dollars. Most significant was that 36.2% stated that they appeal all underpayments regardless of the underpayment amount while 4.8% stated that they never appeal underpayments.

28 respondents chose to select the 'other' field to further explain their answers to this question. Several stated that, due to ambiguity and confusion over contracts and fee schedules, it is difficult to know whether they were paid the correct amount in the first place. Others stated that they use a percent of submitted charge rather than a dollar amount as a threshold. Many stated that it depended if it was a one-time occurrence or a pattern of underpayment.

Questions 6 and 7 dealt with practices demographics. Question 6 asked about specialty and the top 80% (with ties) are as follows:

Specialty	Count	Percent	CumPer
Multi-specialty	56	28.87%	28.87%
Orthopedics	18	9.28%	38.14%
OB/GYN	15	7.73%	45.88%
Family Practice	13	6.70%	52.58%
Cardiology	9	4.64%	57.22%
Dermatology	8	4.12%	61.34%
Gastro	8	4.12%	65.46%
Internal Medicine	7	3.61%	69.07%
General Surgery	6	3.09%	72.16%
Neurosurgery	6	3.09%	75.26%
Neurology	5	2.58%	77.84%
Otolaryngology	5	2.58%	80.41%
Pediatrics	5	2.58%	82.99%
Primary Care	5	2.58%	85.57%
Urology	5	2.58%	88.14%

Question 7 asked about the state in which the practice was located. The top 80% (with ties) are reported below:

State	Count	Percent	CumPer
FL	25	11.16%	11.16%
OH	23	10.27%	21.43%
IL	15	6.70%	28.13%
TN	15	6.70%	34.82%
CA	14	6.25%	41.07%
TX	12	5.36%	46.43%
OR	10	4.46%	50.89%
IN	7	3.13%	54.02%
KY	7	3.13%	57.14%
NY	7	3.13%	60.27%
SC	6	2.68%	62.95%
WA	6	2.68%	65.63%
MO	5	2.23%	67.86%
PA	5	2.23%	70.09%
GA	4	1.79%	71.88%
MI	4	1.79%	73.66%
MT	4	1.79%	75.45%
NC	4	1.79%	77.23%
NJ	4	1.79%	79.02%
OK	4	1.79%	80.80%
WI	4	1.79%	82.59%

CONCLUSIONS

While I was not surprised by the percent of denials reported, I was surprised by the frequency with which practices appealed denied claims and the rate for which reversals were won. According to Mark Rieger, CEO of National Healthcare Exchange Services (www.nhxs.com), the average cost of an appeal to a medical provider is $25 and around $65 for the payer. Assuming our estimate of total claims is correct, this translates to nearly $5 billion in rework (waste) for providers and over $12 billion is rework (waste) for payers. That nearly 70% of all denials are reversed at a cost of over $17 billion in waste each year is a scathing indictment on our healthcare claims process. Lack of transparency regarding edits, ambiguity of rules and regulations, the complexity that surrounds the ability to file a clean claim and what appears to be the inappropriate denial of tens of millions of claims contributes significantly to the overall cost of providing physician services.

Certainly more study is necessary to develop causal relationships regarding the results of this brief survey. But maybe more important is the need to simplify the claims process. Rules are complex as well as complicated. There is an uneven enforcement of HIPAA and other standards within our industry. For each denial, there are 5 group codes, 250 reason codes and 670 remark codes that can be used to explain why a claim was denied. According to the AMA"s National Health Insurance Report Card, these codes are used inconsistently both within and between payers to often times describe the same reason for a denial. Failure of the payers to read past the first ICD-9 code and/or modifier results in unnecessary denials. There are somewhere in the neighborhood of 2 million different edits applied by payers to deny a claim and/or reduce payment. Eligibility alone accounts

for nearly one third of all denials; a problem that could easily be resolved were both practices and payers to utilize existing technologies to electronically verify eligibility. Inasmuch as there are a handful of payers that account for 80% of all claims processed versus nearly three quarter of a million physicians, I believe that they bear the primary burden to initiate the steps necessary to fix this expensive and wasteful problem.