

THE PRICE NOBODY CHARGED · CHAPTER FOUR

The Claim That Came Back

A denied claim is usually born at the first desk, weeks before it comes back.

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THE LICENCE

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A NOTE BEFORE YOU READ

This work is offered for education and leadership development. It is not legal, financial, accounting, investment, medical or psychological advice; take the advice of a qualified professional who knows your circumstances. Companies and events are described from the public record as the author understands it; characterisations are the author's analysis. Examples are illustrative, and no particular outcome is promised to any reader.

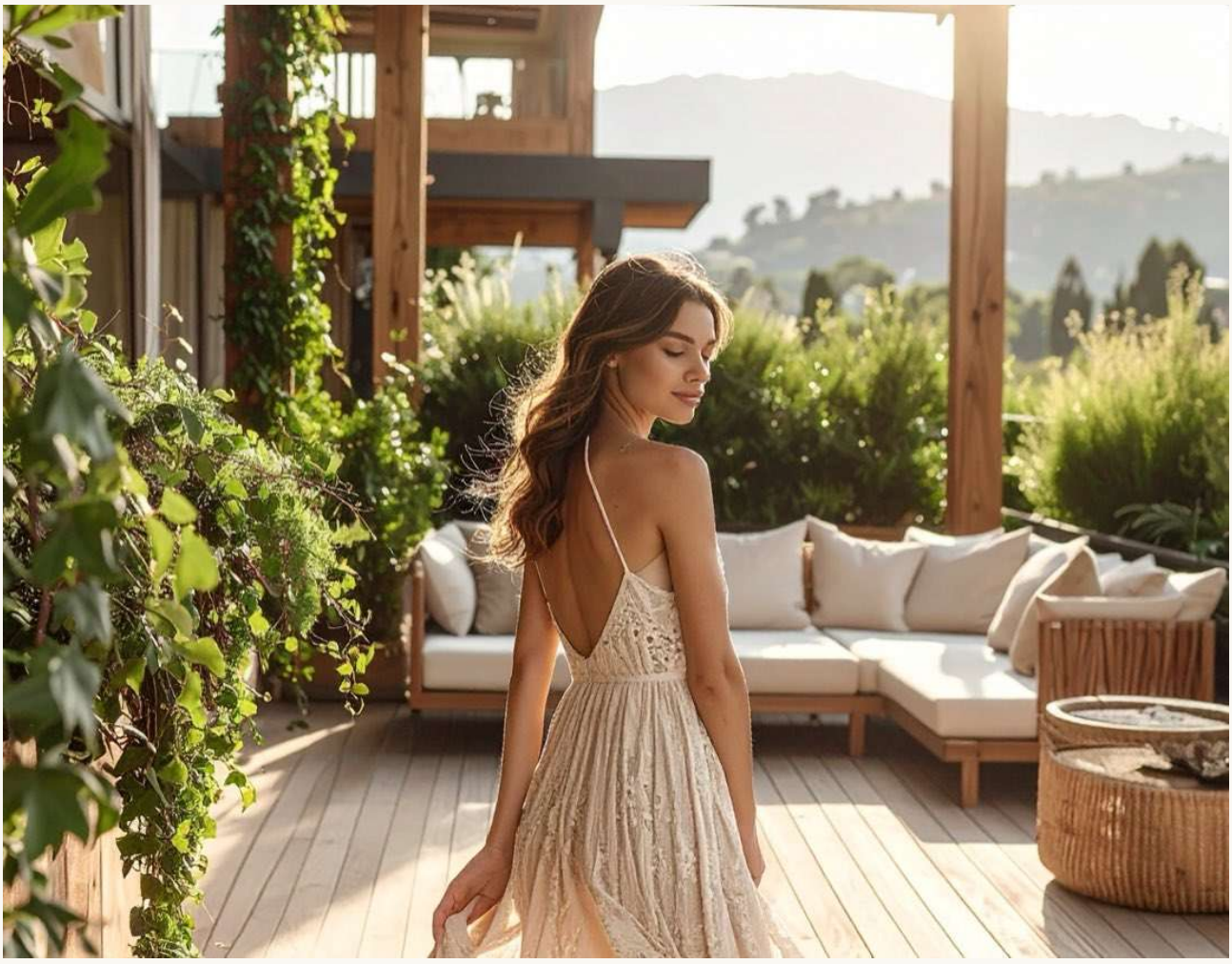
ABSTRACT

A denied claim is usually born at the first desk, weeks before it comes back. It is a quarter past seven on a Wednesday, and the billing coordinator of a family medicine practice is at her desk before the first patients arrive. The practice has eight doctors and serves a mixed neighbourhood: families with employer insurance, older patients on Medicare, a good number on Medicaid. Her screen shows the week's denials, claims the insurers have sent back unpaid. There are a hundred and forty of them. She has time, realistically, to work about sixty before Friday. The first one is ordinary. A woman was seen in January for a chest infection, and the claim was sent to the insurer on her file. The insurer has replied that her coverage ended on the thirty-first of December. She changed jobs over the holidays. Her new card was in her purse the whole time. Nobody at the front desk asked to see it, because she had been a patient for six years and her details were on the system.

CHAPTER FOUR

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Quarter past seven, the denial queue

It is a quarter past seven on a Wednesday, and the billing coordinator of a family medicine practice is at her desk before the first patients arrive. The practice has eight doctors and serves a mixed neighbourhood: families with employer insurance, older patients on Medicare, a good number on Medicaid. Her screen shows the week's denials, claims the insurers have sent back unpaid. There are a hundred and forty of them. She has time, realistically, to work about sixty before Friday.

The first one is ordinary. A woman was seen in January for a chest infection, and the claim was sent to the insurer on her file. The insurer has replied that her coverage ended on the thirty-first of December. She changed jobs over the holidays. Her new card was in her purse the whole time. Nobody at the front desk asked to see it, because she had been a patient for six years and her details were on the system.

The coordinator knows what happens next. She will ring the patient, get the new details, and resubmit the claim to the right insurer, and if she is quick it will be paid. If she is not quick, it will pass the new insurer's deadline for filing, and it will be written off. Some of the hundred and forty will be. Her jaw is set in the way it is set every Wednesday, before she has opened the second claim.

She is a composite, drawn from the way these mornings are described in the research below and in the house's own practice, and no practice is meant. The research, as it happens, is unusually precise about her week.

Ammanuel Santa Anna's canon, writing about the cost to people of work that has lost its connection to purpose, uses a healthcare example that hangs over this whole subject.[13] It describes "the slow erosion that happens when a healthcare worker is forced to prioritize billing metrics over patient care." Anyone who writes about medical billing has to keep that sentence in view. The argument of this chapter is not that doctors should think more about money. It is that a practice which bills well, at the first attempt, frees its people to think about money less.

This chapter makes one claim. A denied claim is revenue earned for care already given, and in most practices it is lost not at the desk that receives the denial but at the desk where its cause began, weeks earlier, in a question nobody asked. The leak is fixed upstream, at the first desk, and the practice that fixes it gains the money, the time spent chasing it, and, as the research shows, the patients it would otherwise have learned to avoid.

Remittance data, 2013 to 2015

Most of what is said about denials comes from consultancies and software vendors, and its figures are rarely traceable to a study. The academic work is smaller, more recent and better grounded, and it begins with the paperwork itself.

In 2018 the economists Joshua Gottlieb, Adam Hale Shapiro and Abe Dunn published a paper in *Health Affairs* on the complexity of billing for physician care.[14] They built new measures of how hard it is to get paid, using a large sample of what the industry calls remittance data, the detailed records insurers send back about each claim, for 2013 to 2015. They found, in their own words, "dramatic variation across different types of insurance." Fee-for-service Medicaid was the hardest to bill, with a denial rate 17.8 percentage points higher than fee-for-service Medicare. On what they called conservative assumptions, they estimated that the health care sector deals with eleven billion dollars a year in challenged revenue, and that the figure could be as high as fifty-four billion.

Five years later three of the same authors, with Matthew Sonnenstuhl and Pietro Tebaldi, published a fuller study in the *Quarterly Journal of Economics* under a title that puts the subject plainly: *A Denial a Day Keeps the Doctor Away*.[15] They followed the back-and-forth between a large sample of American physicians and many different insurers, claim by claim, through denials and resubmissions, and used it to estimate what billing problems cost doctors: the cost of the haggling, plus the revenue never collected at all. Their estimate is that "physicians lose 18% of Medicaid revenue to billing problems, compared with 4.7% for Medicare and 2.4% for commercial insurers."

That is the leak, measured. It is not the price an insurer pays for a visit. It is the share of that price that never arrives, or arrives only after work that costs almost as much as it recovers. And it differs enormously by who is paying, which is the first clue that it is not caused by the doctors.

The variation is worth dwelling on, because it says where the leak lives. The same doctor, seeing two patients with the same complaint on the same afternoon, writing the same kind of note, can be paid at the first attempt for one and refused for the other, because the two patients' insurers have different rules, different forms and different ways of saying no. The work of medicine is the same. The work of being paid for it is not. That is why billing problems cannot be fixed by asking doctors to be more careful, and why they are so often treated as nobody's problem in particular. They live in the interface between a practice and dozens of payers, each with its own requirements, and a practice that does not know which of its own desks meets which requirement has no way of seeing where its revenue goes.

What billing costs before anything goes wrong

The coordinator's hundred and forty denials sit on top of a cost that exists even when every claim is paid first time. In 2018 Phillip Tseng, Robert Kaplan, Barak Richman, Mahek Shah and Kevin Schulman published a study in *JAMA* of the administrative cost of physician billing at a large academic health system.[16] They used a method borrowed from management accounting, time-driven activity-based costing, interviewing administrators and physicians to map the path a claim takes through what the industry calls the revenue cycle, and then costing each step.

Their estimates for a primary care visit were thirteen minutes of billing and insurance-related work and about twenty dollars and fifty cents. For a discharged emergency visit, thirty-two minutes and about sixty-one dollars. Measured against the professional revenue of each encounter, they estimated that billing costs ran to 14.5 per cent for primary care visits and 25.2 per cent for emergency visits. It is one health system, studied by interview rather than by stopwatch, and its figures are estimates. But it gives the coordinator's week a scale. Every claim already costs the practice real time to send. Every denial costs that time again, and more, to recover.

This is the reason the house is interested in medical billing at all, and it is worth saying plainly what that interest is and is not. It is not an interest in charging patients more, or in coding visits more aggressively than the care given warrants. Both are wrong, and the second is fraud. It is an interest in the revenue a practice has already earned, for care it has already given, at prices it has already agreed with insurers, which it then fails to collect because of something that happened at its own front desk. That revenue belongs to the practice by every standard anyone would apply. Its loss is pure waste.



The patients a denial costs

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The patients a denial costs

The most important finding in the *Quarterly Journal* study is not about money. Dunn and his colleagues used physicians who moved between states, and practices whose patients live on both sides of a state line, to ask what doctors do when billing a particular insurer is hard. They found that physicians respond to billing problems "by refusing to accept Medicaid patients in states with more severe billing hurdles." And they found that these hurdles were, in their words, "quantitatively just as important as payment rates for explaining variation in physicians' willingness to treat Medicaid patients."

Read slowly, that is a finding about who bears the cost of a denial. It is not only the practice. It is the next patient on Medicaid who rings for an appointment and is told the practice is not taking new patients with her insurance, because the practice has learned, one denied claim at a time, that treating her is unusually hard to be paid for. The authors' own conclusion is that administrative frictions "have first-order costs for doctors, patients, and equality of access to health care."

That changes what fixing a denial is for. A practice that bills its Medicaid claims correctly at the first attempt is not only recovering its revenue. It is removing one of the reasons it might otherwise close its doors to the patients who most need them. The gain from fixing the leak does not come at anyone's expense. It is net generative in the plainest sense: the practice is paid what it was owed, the insurer pays what it agreed, and the patient can be seen.

Born at the front desk

The coordinator's first claim of the morning shows how a denial travels, and it is worth following it backwards.

It was born in January, at the front desk, in the thirty seconds between the patient giving her name and being asked to take a seat. The receptionist confirmed her date of birth and her address. She did not ask whether the patient's insurance had changed, because the practice's routine was to check insurance cards at the first visit and when a patient mentioned a change. The claim was created that afternoon from the visit record, coded by the doctor's notes, and sent automatically overnight. It travelled to the old insurer, which took three weeks to reply. The reply arrived in the coordinator's queue in the middle of February, sorted by the value of the claim, which was small. She reached it in March.

Every person in that chain did their job as it was defined. And the one fact that would have prevented the denial, a new insurance card, was available at the front desk in January, in the patient's purse, for the cost of one question.

The pattern repeats across the queue, with different desks. A denial for a missing prior authorisation began in the referral, when nobody checked whether the insurer required approval before an MRI. A denial for a code the insurer did not accept began in the doctor's note, which did not record the detail the code needed. A denial for late filing began in the coordinator's own queue, where a small claim waited too long behind larger ones. In each case the denial is discovered by the person with the least power over its cause, weeks after the cause, in a department that does not speak to the desk where it began.

Santa Anna's canon on keystone roles describes the work that sits in exactly that gap: "The translational work that bridges organizational silos is invisible on the org chart." The coordinator does translational work all day. She translates insurers' refusals into phone calls to patients and messages to doctors. She does not translate them back into a change at the front desk, because nobody has asked her to, and because the front desk does not report to her.

Readers of Where the Flow Stops will recognise her from its chapter on the night nurse who fetched clean linen from another ward. The researchers who observed that nurse called her kind of response first-order problem solving[17]: the immediate problem is fixed, and the cause is not reported to anyone who could re-

move it. The coordinator resubmits sixty claims a week. Each resubmission is first-order. The front desk's question is never changed, and next January the same denial will arrive.

There is a reason the practice does not see this, and it is in how the losses are recorded. A claim that is written off after the filing deadline passes appears in most practice systems as an adjustment, filed alongside the ordinary differences between what a practice bills and what its contracts with insurers pay. Nobody looking at the practice's accounts can tell a lost January chest infection from a routine contractual discount. The canon describes the norms of a group as "shared, often unspoken agreements about what is expected, permitted, and prohibited within the relational space." The practice's unspoken agreement is that denials are billing's problem. Its accounts are built to agree.

The doctor's note, and the patient's letter

Two desks in the chain deserve their own account, because they are the ones a practice is most tempted to treat badly.

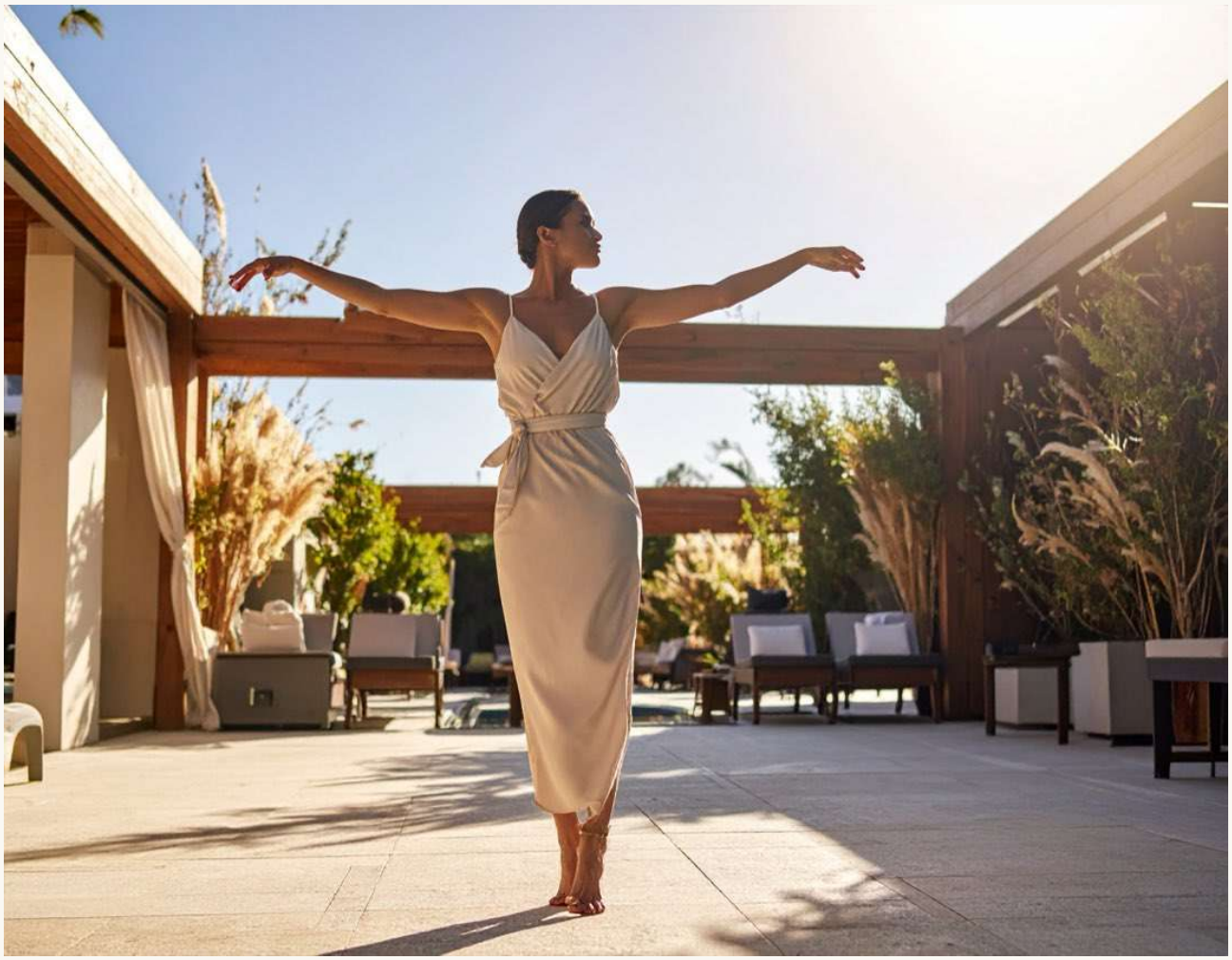
The first is the doctor's. A share of the coordinator's queue every week is documentation: claims the insurer refused because the note did not record what the code required, the duration of a visit, the detail of an examination, the reason a test was ordered. The temptation is to send these back to the doctors as complaints, one at a time, with a request to amend the note. That is the route the canon's sentence about billing metrics warns against. Tseng and his colleagues estimated that the physician's own share of billing work for a primary care visit was small, a median of about three minutes, against thirteen for the visit as a whole. Those three minutes are taken from the end of a clinic, from the time a doctor has to think about the patient she has just seen. A practice that adds to them, claim by claim, is buying its revenue with the attention it exists to give.

The better route is the one the walk takes. Documentation denials are sorted by the kind of detail that was missing, and the pattern is shown to the doctors once a month, in ten minutes at a meeting they already hold: these four things, missed this often, cost this many claims. The doctors decide, together, how their notes will capture them, often with a change to the template the notes are written in rather than to anyone's habits. A pattern shown is information. A claim returned is an interruption. The difference is whether the doctor experiences billing as a system she helps design or as a stream of small accusations arriving after her clinic.

The second desk is the patient's kitchen table. A claim that is denied, and not resubmitted in time, does not always disappear into the practice's adjustments. Sometimes it becomes a bill, sent to the patient, for care she believed was covered. The woman with the chest infection did nothing wrong; she changed jobs over the holidays, and her new insurance would have paid. If the coordinator does not reach her claim before the deadline, the woman may receive a letter in the spring asking her to pay for a visit she had forgot-

ten about, for reasons nobody explains. She will ring the practice, upset, and the person who answers will be the receptionist who did not ask about her card.

That letter is the leak arriving at the one person in the chain who had no part in causing it. It costs the practice the revenue, and then it costs the practice the patient's trust, and it costs the receptionist a difficult phone call she will not connect, unless someone shows her, with the question she was never told to ask. Recovering the claim at the first attempt is the only version of this story in which nobody is hurt.



The denial walk

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The denial walk

What changes this is a way of reading the queue, and it begins by sorting it differently.

The coordinator asks the practice manager to give her two hours on a Thursday, away from the queue, with the last month's denials printed out. They sort them, not by value, as the queue does, but by cause: coverage

and eligibility, prior authorisation, documentation and coding, filing deadlines, everything else. The sort takes most of the first hour. When it is done, one pile is plainly larger than the others. More than a third of the month's denials began with insurance details that had changed since the patient's last visit.

Then they walk three claims from that pile backwards, as the coordinator's first claim was walked above, desk by desk, from the denial to the moment the patient arrived. At each desk they ask what the desk knew, what it did not know, and what single question would have closed the gap. All three walks end at the front desk, at the same thirty seconds.

The change they make is small, and it is made at the first desk. From the next Monday, every patient is asked at every visit, *Has your insurance changed since we last saw you?*, and the receptionist scans the card if it has. The practice manager explains it to the front desk as what it is, a way of making sure the practice is paid for the care the patient is about to receive, and so of keeping the practice able to see patients like her. The receptionists, it turns out, had noticed for years that some patients mentioned new jobs in passing. Nobody had told them it mattered.

The first month is not smooth. Some patients are irritated to be asked the same question at every visit, and the receptionists learn to explain it in a sentence: the practice wants the right insurer to pay, so that nobody gets a bill by mistake. One receptionist asks whether she will be blamed for the denials that still come through, and the practice manager answers, in front of the others, that the walk is about the question, not about who forgot to ask it. By the fourth week the receptionists have started catching other things: a patient whose employer has changed insurers without telling her, a child added to a parent's plan under a new member number. They write them on a sheet by the desk, and the coordinator collects it on Fridays. Without anyone designing it, the front desk has become the first place billing problems are found rather than the first place they are made.

The house's Luminous 100 has a sentence about the most demanding process discipline in modern operations that fits this exactly. In its account of Six Sigma it advises: "Apply DMAIC's rigor to processes that genuinely benefit from standardization". The front desk's thirty seconds is such a process. The same entry is careful to separate the variation worth removing from the variation worth protecting, and it distinguishes "between wasteful variation (genuine inefficiency to reduce) and generative variation (developmental experimentation to protect and nurture)". A receptionist's warmth with a frightened patient is the second kind, and nothing in the new question touches it. A missed insurance card is the first.

Two further habits make the walk stick. The denials are counted every week by cause and written on the board in the staff room, so that the front desk sees its pile shrink and the doctors see theirs. And every write-off is recorded with its reason, not as an adjustment, so that the practice can read, for the first time, what it is losing and where. The canon on acknowledgment describes the right expectation for practices like these: an "ongoing organizational practice — more like hygiene than surgery." The walk is not done once. It is done every month, on whichever pile is largest, and the largest pile changes.

There are predictable ways for it to go wrong. The walk is done on the largest claims rather than the most common causes, and fixes the rare expensive problem while the ordinary one continues. The new question becomes a form the patient fills in and nobody reads. The doctors' pile, documentation, is handed to the doctors as a complaint rather than shown to them as a pattern, and they hear it, as the canon warns, as one more demand to put billing ahead of care. Or the practice, pleased with its recovered revenue, begins to code more aggressively, which is not recovery at all. Chapter 7 carries the denial walk as a run sheet, with the sort, the three questions at each desk, the board and the signs that it is failing, and a version of it for firms outside medicine; Chapter 6 places it in the order of a first ninety days.

The practice is not unusual, and the walk is not specific to medicine. A manufacturer whose customers deduct money from its invoices, for short deliveries, late arrivals, damaged pallets or promotions they claim were agreed, has a denial queue of its own, worked by someone in credit control who resubmits and writes off and never tells the warehouse. The same sort by cause, the same walk to the first desk, applies. So does the lesson of the unbilled week in a professional firm (Chapter 2): revenue that is earned and not recorded at the moment it is earned is revenue that the organisation will spend money, later, failing to recover.

And the gain, before anyone shares in it, has to be measured against the practice's own history, in a form both sides could sign (Chapter 5), which for a practice means counting denials prevented, not only denials won.

Walking your own denials

The denial walk is the most specific practice in this book, because the setting is specific, and also the one that travels furthest. The book can carry the finer points of both.

The first is the sort. Use the last full month of denials or, outside medicine, of short payments and customer deductions. Sort them by cause, in a few plain categories the team can apply without argument: who is covering the patient or the account; permission that was needed in advance and not obtained; what the record said or failed to say; deadlines missed; and everything else. The insurers' and customers' own reason codes help, but they are written for their purposes, not yours, and several codes often describe one cause. Sort by what would have prevented the denial, not by what the payer called it.

The second is choosing the claims to walk. Take three from the largest pile, ordinary ones, of ordinary value. A single large claim is tempting and misleading, because large claims are often unusual. Walk each backwards from the denial to the moment the patient arrived or the order was placed, and at every desk ask what it knew, what it did not know, and what single question would have closed the gap. Write the question down in the words the desk would use.

The third is the change at the first desk. It should be one question or one check, short enough to ask in every encounter, and explained to the people who will ask it in terms of what it does for the patient or the

customer, not for the billing team. Give them a sentence for the patients who ask why. And give them a place to note what they find, because they will begin to find more than the one thing they were asked to look for.

The fourth is the doctors, or whoever in another firm writes the record the payment depends on. Show them patterns, monthly, in a meeting they already attend, never single claims by message. Let them decide how the record changes, and look first for a change to the template rather than to their habits. A practice that turns its clinicians into billing clerks has recovered its revenue by spending its medicine.

The fifth is the write-off. Every claim or deduction written off is recorded with its cause, not as an adjustment, and the total by cause is read once a month. It is the only number in the walk that shows the cost of doing nothing, and most systems hide it by default.

The sixth is the measure. The most useful single figure is the share of claims paid at the first submission, read by cause and by payer, against the practice's own history over a year. It counts denials prevented, which is the gain, rather than denials won on appeal, which is a cost recovered at a cost.

The seventh is the line the practice does not cross, and it needs saying in writing at the start. The walk recovers payment for care actually given and properly recorded, at the rates the practice has agreed. It never adds to the record what did not happen, never chooses a code for its price rather than its accuracy, and never presses a patient for what an insurer owes. A practice should have its billing reviewed by people qualified to do so; nothing in this chapter is billing, coding or legal advice.

Outside medicine the walk is the same. A manufacturer's deductions for short deliveries begin in the warehouse; deductions for late arrival begin in the booking of the carrier; deductions for promotions begin in a conversation between a sales representative and a buyer that nobody recorded. Credit control receives them and works them one at a time. Sorted by cause and walked to the first desk, they turn out, as the practice's denials did, to be a handful of questions nobody asked.

And the decision that most changes the result is that the walk is repeated. Once a month, on whichever pile is largest. The largest pile changes, and the walk goes with it. Chapter 6 places the first walk in the middle of the ninety days, and Chapter 7 gives the sort sheet, the walk sheet, the first-desk question and the monthly board.

Quarter past seven, the next spring

It is a quarter past seven on a Wednesday in April, and the billing coordinator is at her desk before the first patients arrive. The week's denials are on her screen. There are seventy-one of them. On the board in the staff room, the coverage pile for the month is a third of the size it was in the autumn, and the front desk has drawn a small line under it, in marker, the way the receptionists asked to.

The first denial of the morning is for a prior authorisation, and she makes a note to walk it on Thursday.

The second is for a woman seen in January for a chest infection, a different woman, with a new job. It is not a denial. It is a payment, from the right insurer, at the first attempt.

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