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Struggling with COB Denials? Why It's Time to Revamp Your Approach

by Lorrie Wood, CRCR

One of the most common hospital denials—coordination of benefits (COB) denials—puts 1% of net patient revenue at risk each year. Yet up to 65% of denied COB claims are never corrected and resubmitted for reimbursement. For hospitals, it's a missed opportunity to capture revenue for care and services delivered.

Consider that 70% of COB denials are approved after they are corrected and resubmitted. Yet often when hospitals receive COB denials, revenue cycle staff may attempt to reach the patient by phone and letter, but when that proves to be unsuccessful these balances are identified as "patient responsibility," and in some cases discounted to self-pay rates. This scenario not only diminishes revenue, but also tarnishes the patient experience by putting the brunt of responsibility for payment on the consumer.

The revenue opportunity can be substantial: At one multi-hospital health system in the East, failing to recover insurance dollars by correcting COB claims cost the health system over $1.2 million in lost revenue per month across 255 patients. The impact per year: $15.3 million in missed revenue across 3,000 patients.

The financial pressures hospitals face demand a better approach.

Why Breakdowns in COB Denial Management Occur

COB denials began to rise in 2014, when the Affordable Care Act prohibited insurance companies from denying coverage for preexisting conditions or charging higher premiums to those who have them. So did patient involvement denials, which occur when health plans request additional information from patients—such as eligibility information updates or prior medical history forms—before the claim will be processed.

Sometimes, COB denials stem from annual or biannual COB update requests from health plans. Other common causes include:

- Incomplete or inaccurate COB information on file with the payer
- Care may be covered by another payer
- Medicare Common Working File issues

COB denials are confusing for patients, and they can cause enormous turmoil at a time when patients might already feel vulnerable due to their health status. In one highly publicized incident, a couple from Kansas whose infant daughter spent seven days in neonatal intensive care were charged $270,951 for labor and delivery and NICU care. The reason: The parents weren't aware of the "birthday rule," which required the

daughter's primary coverage to fall under her father's insurance plan. Because the mother's insurance plan was more generous, the parents planned to enroll their daughter only in that plan, not knowing that health plan guidelines require a different approach. The situation took two years to resolve, significantly affecting their healthcare experience.

That's why it's crucial that healthcare revenue cycle departments invest in the resources needed to resolve COB and patient involvement claims. Given that these patients have insurance, they expect the majority of their care to be covered by their plan. When denials arise, revenue cycle departments must serve as an advocate for the patient, working with the insurance company to resolve issues that impede payment.

But capturing the information needed from patients after their healthcare encounter is over is more difficult than revenue cycle teams might anticipate. Sometimes, patients are discharged to a location other than their home address. Communication preferences—from text to email to letters sent by mail—vary by patient, and so does the likelihood that patients will respond.

Further, even when contact has been established, not all patients will follow up with their insurance company to provide the information necessary to process their claim.

Adopting a More Proactive Strategy

Given the challenges associated with correcting COB claims, it's easy to see why revenue cycle employees may be tempted to give up after a couple of attempts to contact the patient. But these accounts shouldn't simply be designated as self-pay when obstacles occur.

As the percentage of COB denials rises, there are three reasons healthcare providers should rethink their process.

1 The potential for revenue recovery is high.

When hospitals attempt to resolve COB and patient involvement denials on their own, their recovery rate typically totals 30%, on average. This figure rises to as high as 75% when organizations invest in outside support, enabling staff to focus on more value-added work while boosting their bottom line.

Exhibit one:

Impact of a COB & Patient Involvement Denials Program on Revenue

COB & Patient Info Denials Program[1]	Health System	Outsourced COB Program
Annual COB & Patient Info Denials $ (Net)[2]	$36,525,000	$36,525,000
Recovery %	30.0%	75.4%
Revenue from COB Recoveries	$10,957,500	$27,539,850
Revenue Improvement		**$16,582,350**

[1] Based on an Knowtion Health analysis of a multi-hospital health system.
[2] Approximately 1% of the Health System's annual net patient revenue.

The challenge lies in putting the missing pieces together. To resolve COB claims, revenue cycle staff must understand the intricacies of COB requirements—including the birthday rule—to determine whether the correct payer was billed as the primary health plan. They must contact patients to confirm coverage. They must also assess whether secondary and/or tertiary coverage exists, in part by reviewing all associated accounts within the billing system. These can be time-consuming tasks. Revenue cycle leaders must consider: "Is my staff's time best spent on these activities? Or, is there greater return on investment from outsourcing this work?"

2 Efforts to resolve COB denials significantly reduce bad debt.

If your organization isn't actively correcting COB claims, your chances of mitigating other types of denials plummets. That's because payers will perceive a lack of action as a sign of complacency, and they will have limited incentive to work with your organization to resolve claim delays or denials.

Every payer contract contains an implied covenant of good faith and fair dealing. When a payer violates this covenant—such as by requesting COB annually or biannually just to delay paying the claim—hospitals need a strategy for recovering revenue for services delivered. The question is, does your organization have the time and expertise to hold payers accountable in scenarios such as these? Further, would the time and effort spent responding to COB denials match the recovery rates and timeframes of a third-party expert?

It's important to note that a COB denial may need to be reprocessed more than once before an organization receives payment. This effort requires not just persistence, but also careful tracking of which claims were resubmitted, when, and the status of recovery efforts across claims and health plans.

3 Timely engagement is critical to revenue recovery.

COB claim denials are complex, and many cannot be resolved without the patient's assistance. This puts pressure on staff to engage both the payer and the patient in a timely manner. Revenue staff tasked with contacting patients must possess a strong understanding of how to effectively gain patients' full involvement.

In our experience, multi-channel communications—from texts to emails, auto dialers and letters—produce the best results. In fact, we've found that the style of envelope matters when mailing print communications, with colorful envelopes and mailers more likely to spark a response than standard business envelopes. The time of day when contact is initiated also makes a difference not just in whether a patient responds, but how quickly.

Typically, a "once and done" approach to communication is not sufficient. Because so much handholding is involved, hospital revenue cycle teams often find that they need third-party assistance in initiating and managing these conversations if they are to achieve the desired recovery rate.

An Ounce of Prevention

Overturning COB denials is complex work, but hospital revenue cycle teams needn't go it alone. By investing in a more strategic model for preventing and responding to COB denials, with a focus on the right support at the right time, hospitals can more effectively bolster recovery rates while strengthening the patient experience.

Find out how Yale New Haven Health turned around its cash collections and improved aging accounts receivable and the patient experience by creating a more sustainable approach to COB denials management.
Read the case study.

About the author:

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