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Why You Can't Afford to Wait on Your COB Denials

by Lorrie Wood, CRCR

UP TO 65% OF DENIED CLAIMS are never corrected and resubmitted for reimbursement. In the case of coordination of benefits (COB) denials and other patient information denials, that's a substantial source of missed revenue, given that 70% of COB denials are approved after they are corrected and resubmitted.

COB denials rank among the most common hospital denials. Since 2014, when the Affordable Care Act prohibited insurance companies from denying coverage for preexisting conditions or charging higher premiums to those who have them, providers have seen a substantial increase in COB denials. Also on the rise: patient involvement denials, or instances where health plans request additional information from patients to process the claims, such as eligibility information updates or prior medical history forms.

Often when hospitals receive COB denials, revenue cycle staff — after trying to reach the patient by phone and by letter — identify these denials as "patient responsibility" and charge the patient a self-pay rate. When this happens, revenue cycle teams leave insurance money on the table. 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.

Further, a report from the Council for Affordable Quality Healthcare found that while the number of COB transactions performed by healthcare organizations increased from 2019 to 2020, the healthcare industry could still save $19 million by strengthening efficiency around these transactions.

The financial pressures hospitals face demand a better approach. Patients who have insurance shouldn't be designated self-pay patients when COB denials present challenges for revenue cycle staff. As the percentage of COB denials rises, there are four reasons healthcare providers can't afford to wait to improve their process.

No. 1: Significant potential for increased revenue recovery.

COB and patient Involvement denials put up to 1% of net patient revenue at risk. Sometimes, these claims stem from annual or biannual COB update requests. 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

When hospitals attempt to resolve COB denials on their own, their recovery rate typically totals 30 percent, on average. This figure rises to as high as 75% when organizations invest in outside support. It's a move that empowers hospitals to deploy staff to more value-added work while significantly strengthening their bottom line.

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.

No. 2: Implications for patient satisfaction and the patient financial experience.

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 following complications during delivery 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 had thought they would enroll their daughter only in that plan. The situation took two years to resolve, leaving a bad impression on the family.

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.

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 tertiarycoverage 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?"

No. 3: The opportunity to markedly reduce bad debt.

If your organization isn't actively correcting payers acting in bad faith or with lack of fairness around COB claims, your chances of preventing and mitigating other types of denied or delayed claims also plummets. 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 issues that arise.

Every payer contract contains an implied covenant of good faith and fair dealing. When a payer violates this covenant– such as by asking for COB just to delay paying the claim, failing to release claims even when the COB forms are on file, or relying on timely filing rules to deny claims in unjustifiable, unfair circumstances–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?

One important consideration is 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.

No. 4: The importance of timely engagement in optimal revenue recovery.

COB claim denials are complex, and many cannot be resolved without the patient's assistance. This

puts pressure on staff to not only engage the right payer in a timely manner, but also the patient. 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–are needed to produce optimal 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. Further, the time of day when contact is attempted makes a difference in whether a patient responds and how quickly a response is received.

Typically, a "once and done" approach to communication is not sufficient. Providers must plan to frequently contact the payer to determine whether an issue is still outstanding. They must also have a robust strategy for patient follow-up when additional information is needed. 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 financial experience.

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