# Current Trends and Recommended Strategies for Appeals Management for Laboratories and Pathology Practices

Front-end edits and configurations help mitigate backend denials. Capturing potential denial-related issues proactively is the most effective way to maintain a manageable AR and improve the propensity for reimbursement. That said, some levels of denials are unavoidable, and not all known issues can be addressed at the front end of the revenue cycle management (RCM) process.

An example of this is denial code CO252, which is an additional information denial. When received, it indicates the payor is requesting a pathology report on services performed before issuing payment – essentially performing an audit to ensure the services billed are warranted and documented. These are not always complex molecular tests; they can be routine pathology claims. These CO252 denials can be appealed with a pathology report. Though it is inevitable, an organization must wait for the denial before it can take action.

In situations such as this, a robust appeals process, with automation, is critical. In molecular testing in particular, appeals carry a heightening impact on revenue collection. In 2020, XiFin found that appeals accounted for 5% of the total revenue generated by XiFin customers. In 2021, that rate increased to 6.5%.

Based on an analysis of 25 million claims with 2021 dates of service, XiFin found that payment collection per appeal continues to be stable both in the pathology segment (averaging 1-2%) and the clinical segment, where appeals are less prolific. Revenue recovered by corrected claims is excluded from the data seen in the chart below, since these claims follow a separate process and impact denial codes such as CO97 (Procedure or service isn't paid for separately), CO18 (Duplicate), and CO234 (Procedure not paid separately).

| Segment | Appeal-Payments as % of Total Insurance Payments Received | Average Payment Amount per Appeal |
|---|---|---|
| Clinical | 0.11% | $121 |
| Molecular | 6.56% | $1,420 |
| Pathology | 1.12% | $327 |
| **Industry Average** | **3.39%** | **$623** |

Furthermore, a single appeal attempt is not sufficient. While the volume of appeals decreases with each attempt, the success of collecting each round remains consistent.

### Appeal Trends: Clinical Laboratory

The clinical laboratory segment maintains the lowest volume of denials. Low denial volumes, however, do not negate the need for robust editing processes. Implementing robust front-end logic and leveraging intelligent automation to correct potential issues dramatically streamline the process from submission to payment, especially in the high-volume clinical laboratory segment.

As seen in the chart below, many appeals are paid after the second or even third attempt. This is why an automated, cost-effective appeals process is valuable, even in segments with a low overall volume of appeals.

| | % of Total Appeals Filed | % of Appeals Paid after 1st Attempt | % of Appeals Paid after 2nd Attempt | % of Appeals Paid after 3rd Attempt | Avg Payment per Appeal |
|---|---|---|---|---|---|
| Clinical | | 17.4% | 17.8% | 9.9% | $ 276 |
| Additional Information | 70.1% | 20.9% | 20.3% | 10.0% | $ 258 |
| COVID Medical Necessity | 8.9% | 3.9% | 50.0% | | $ 78 |
| Medical Necessity | 4.8% | 30.4% | 18.4% | | $ 553 |
| Out of Network | 6.9% | 4.4% | 2.4% | | $ 594 |
| Prior Authorization | 0.0% | 14.3% | 0.0% | | $ 421 |
| Underpayment | 9.3% | 6.9% | 6.3% | | $ 10 |

### Appeal Trends: Molecular

At $1,420, the average payment per appeal for molecular testing is more significant due to the high-dollar value of the testing. As illustrated in the chart below, additional Information appeals account for 47% of the total appeals filed by XiFin customers in 2021 in the molecular segment and have an average success rate of 23%. Another 23% of appeals are for molecular diagnostic claims denied for medical necessity, followed

by prior authorizations at 11.4% of total appeals filed. Prior authorization appeal volumes have remained consistent year-over-year in the molecular segment, averaging 10% in 2020, despite a higher volume of prior authorization requirements than in the pathology or clinical laboratory segments.

| | % of Total Appeals Filed | % of Appeals Paid after 1st Attempt | % of Appeals Paid after 2nd Attempt | % of Appeals Paid after 3rd Attempt | Avg Payment per Appeal |
|---|---|---|---|---|---|
| **Molecular** | | **21.4%** | **17.2%** | **19.4%** | **$1,420** |
| Additional Information | 47.7% | 23.9% | 20.7% | 23.3% | $1,285 |
| Medical Necessity | 23.0% | 17.6% | 14.0% | 12.8% | $1,518 |
| Prior Authorization | 11.4% | 18.9% | 11.7% | 13.1% | $1,944 |
| Experimental and Investigational / Non-Covered | 5.6% | 13.2% | 9.0% | 9.0% | $4,234 |
| COVID Underpayment | 3.8% | 44.7% | 24.6% | 10.7% | $52 |
| Timely Filing | 3.5% | 10.1% | 8.3% | 18.9% | $551 |
| Out of Network | 3.5% | 14.0% | 10.8% | 8.4% | $2,513 |
| Underpayment | 1.1% | 31.2% | 17.8% | 15.3% | $2,154 |
| COVID Medical Necessity | 0.4% | 46.4% | 27.0% | 0.0% | $124 |

It is a XiFin recommended practice to integrate an organization's RCM platform with prior authorization vendors, allowing claims meeting prior authorization criteria to be submitted to a prior authorization solution automatically. Utilizing real-time data exchange helps organizations more quickly acquire the necessary prior authorization data, streamlining the reimbursement process and minimizing the need for a user to touch the claim or spend time making authorization requests by phone. Considering it may take an individual an average of 20-30 minutes to acquire a prior authorization manually, this process significantly reduces the back-end burden of appeals. Timely filing, underpayment, and out-of-network appeals, while smaller in volume, are still fruitful in recovery, particularly in the second and third attempts.

### Appeal Trends: Anatomic Pathology

Approximately 2% of the pathology accessions received by XiFin require an appeal. Those appeals will be responsible for approximately 1-2% of the pathology practice's revenue. Although the revenue reclaimed in the pathology segment is largely attributed to the first attempted appeal, a robust process that includes multiple attempts is critical in revenue recovery in the event the first appeal is not overturned.

| | % of Total Appeals Filed | % of Appeals Paid after 1st Attempt | % of Appeals Paid after 2nd Attempt | % of Appeals Paid after 3rd Attempt | Avg Payment per Appeal |
|---|---|---|---|---|---|
| **Pathology** | | **22.6%** | **20.6%** | **21.8%** | **$327** |
| Additional Information | 33.4% | 28.8% | 23.4% | 27.9% | $337 |
| Medical Necessity | 19.0% | 23.5% | 23.4% | 27.6% | $398 |
| Out of Network | 17.9% | 17.6% | 12.4% | 17.7% | $318 |
| Prior Authorization | 12.2% | 21.5% | 32.9% | 36.5% | $350 |
| Experimental and Investigational / Non-Covered | 9.2% | 17.8% | 8.9% | 3.1% | $195 |
| COVID Underpayment | 5.8% | 9.0% | 3.4% | 16.7% | $31 |
| Timely Filing | 2.5% | 20.5% | 15.6% | 13.3% | $191 |
| Underpayment | 0.1% | 52.2% | 0.0% | | $177 |

The most common appeals in pathology are in response to "Additional Information Required" to adjudicate the claim denial codes. For example, appeal responses for denial code CO252 could include submitting the pathology report for review, providing additional detail on the utilization of unspecified codes for services rendered, and providing medical records or prior authorization codes.

Additional information requests are consistent and predictable, determined by the denial code received. **Where there is consistency, there is the opportunity for automation**. Automating the packaging and submission of appeals saves time and cost and improves the timeliness of payment. Using denial code CO252 as an example, the process for responding is exactly the same every time. So, the RCM system should be able to, in response to this denial code, automatically pull the pathology report, generate a CO252-specific appeal letter, complete a payor-specific form (if required), package the documentation, and submit it automatically to a print vendor. When automated in this way, CO252 denials can be bundled and sent for print within a day of receiving the denial – without a user needing to touch the accession.

Medical necessity denials can be more labor-intensive, depending on the test and payor mixes. The RCM system should be able to house logic to drive appeals based on specific payor ID, denial reason code, and CPT. This ensures that even more complex denials can leverage automation so the process is streamlined, and manual intervention can be minimized, reducing the cost of collection.

### Benchmarking and Improving Productivity

Proactively preventing denials and avoiding the need to submit a corrected claim or file an appeal reduces the time to reimbursement by four to eight weeks, depending on the payor and type of denial. If denials are not addressed properly and manual

workflows persist, diagnostic labs and pathology practices will continue to experience a loss of revenue, and staffing will be insufficient to keep up.

XiFin has found that productivity rates for anatomic and molecular billing teams historically average between 12,000-15,000 accessions per person per full-time equivalent (FTE) per year (clinical laboratory is often much higher). With the increases in denials, however, the resulting demands on back-end teams have increased substantially and this impacts productivity rates. This holds particularly true for non-covered, medical necessity, and prior authorization denials.

By automating appeals, the turn-around time on submitting back to the payor is reduced, on average, from 45 days to 1-3 days. By applying front-end edits to help maximize clean claims, up to an additional 54 days can be saved, moving from 135 days to just 30 days for full adjudication.

Read the full analysis and report on the latest denial and appeals trends on the XiFin **website**.

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