Practical Strategies for Denials Prevention Across the Revenue Cycle

Today's Speakers

Gina Stinson
Sr. Director, Process Excellence

AGENDA

- Industry trends
- Moving from recovery to prevention
- Leveraging analytics to determine root cause
- Best practices in workflow and productivity tracking

Denials

Understanding the industry trend

$3 trillion

claims submitted

> $262 billion denied,

averaging almost
$5 million per hospital

Change Healthcare, 2017. (Initial denials)

Industry average denial rate between **5-10%**

AAFP, 2010. (Initial denials)

65% of claims denials are never re-submitted

MGMA, 2011.

58% of all denials were commercial in 2016, up from 54% in 2015

Healthcare Informatics, 2017.

31%

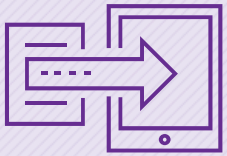
of hospitals manage denials manually

> 60% without an external solution

but plan to purchase one in the next **7-12 months**

HIMSS, 2016.

Market Forces
Contributing to Denials

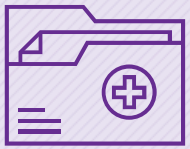


Disparate Systems

Mergers or new system implementations like EHR upgrades, require data to be merged from disparate systems to one centralized system [1]

System Backlogged

A common result is that A/R systems to become backlogged [2]



Inefficiencies

The AMA estimates claims processing inefficiencies cost between $21B and $210B

The Marketplace

State insurance marketplaces with its 90-day premium grace period created additional denial variations and added to the complexities [3]

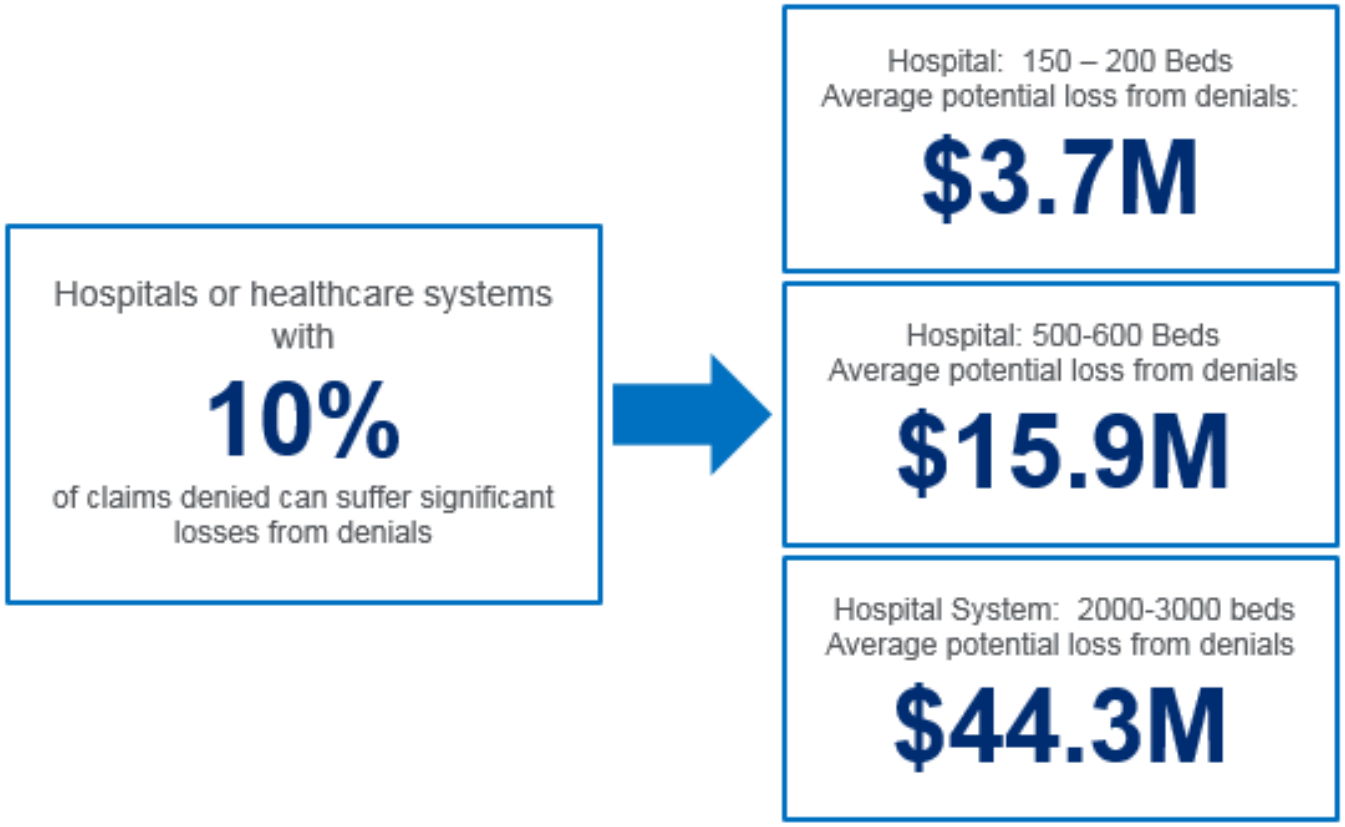
Margin Pressure

Healthcare providers must find new ways to decrease costs, as private payors and employers can no longer absorb shifted costs. [4]

Strategies includes up-front collections, lowering cost to collect, reducing denials, eliminating bad debt write offs, all in effort to drive cash collections.

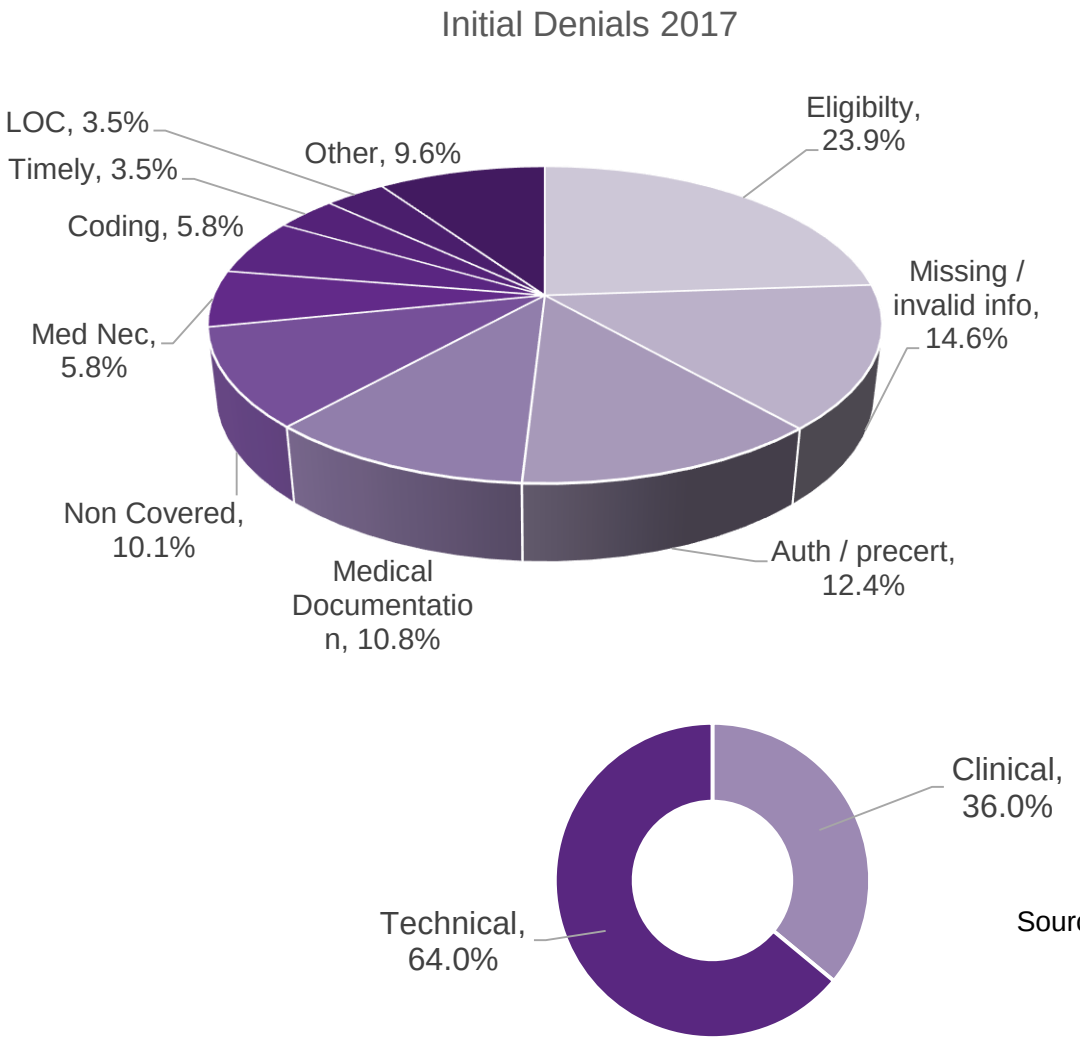
nthrive

Impact to Bottom Line



Average losses calculated from nThrive client financials with industry rates;
10% as the midpoint of 7-12%

Common Denials Trends & Reasons



A typical hospital will have

7-12%

of its claims denied

Best practice is

2-5%

of claims denied

Source: AMA Insurance Report Card 2013; Health Leaders Media;

Source: nThrive client data, 2017

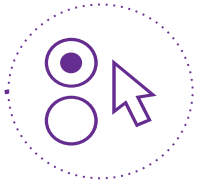
DENIAL MANAGEMENT

Assessing Denials Performance

To accurately
assess performance, capture and review these metrics as a meaningful first step to understanding the impact of denials to your organization

Initial Denial Rate

Calculated by number of zero paid claims denied/number of total claims remitted.



Rate of Appeal / Recovery Effort

How many appeals, rebills, etc. are you sending?

Overturn Rate

Denied accounts overturned & paid, compared to all denied dollars. Communicates recovery effectiveness.

Cost to Recover

Appeals are the most expensive and time-consuming way to collect amounts due. Particularly when cost to recover is high, prevention is the best strategy.

nthrive

No Immediate Clarity on Root Cause

N64 – claim information is inconsistent with pre-certified/ authorized services

No authorization?
Review root cause and address scheduling and access?

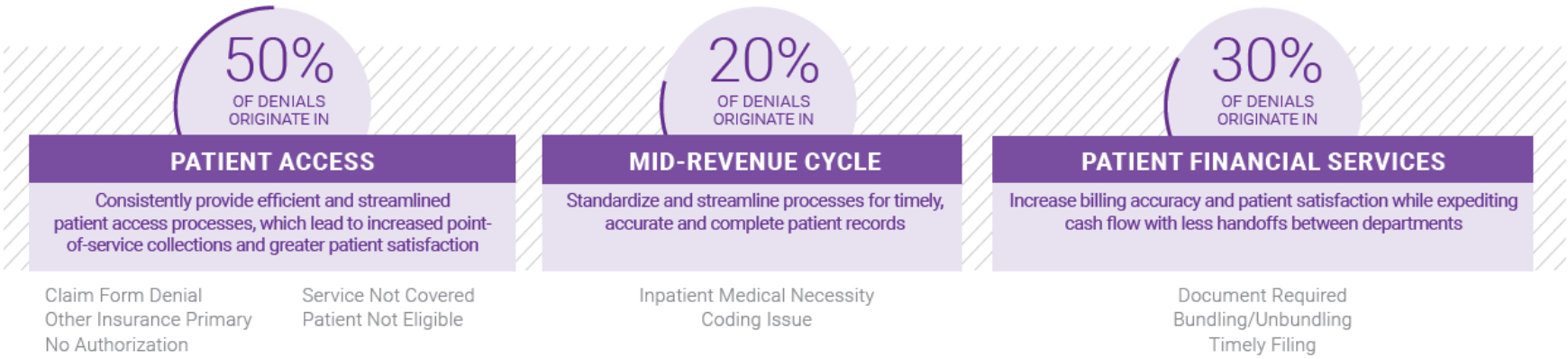
Bundling?
Service is not separately reimbursable, review for possible billing edit?

Service outside of authorization?
Review with treatment team to identify whether additional services were performed and why?

Not a denial?
Notification from payor about known reimbursement policy?

FROM DENIAL MANAGEMENT TO PREVENTION

Denials Occur Across Every Aspect of the Revenue Cycle



Source: nThrive client data, 2017

Denial Prevention Opportunities Exist Across the Revenue Cycle

Revenue Cycle Opportunities for Denial Prevention

Scheduling

- Benefit plan coverage
- Benefit maximums exceeded
- Eligibility
- Experimental procedure
- Authorization
- Pre-existing condition
- Medical necessity
- Credentialing

Access

- Benefit plan coverage
- Benefit maximums exceeded
- Coordination of benefits
- Eligibility
- Experimental procedure
- Authorization
- Pre-existing condition
- Medical necessity
- Documentation

Patient Care

- Medical necessity
- Authorization
- Experimental procedure
- Documentation

HIM, Charge Capture

- Documentation
- Medical necessity
- Experimental procedure
- Authorization
- Benefit plan coverage
- Coding

Billing/Collection

- Bundling
- Coding
- Demographic mismatch
- Documentation
- Eligibility
- Authorization
- Pre-existing conditions
- Timely filing
- Coordination of benefits

nthrive

Reduce Denials in Key Areas: Patient Access

					
Revenue Cycle Step	**Insurance Verification**	**Identity Verification**	**Authorize orders**	**Check medical necessity of the order**	**Quality check on registration data**
Best Practice	Check the patients insurance for their eligibility (what services are covered) and their benefits (co-pay, deductibles). This allows for accurate estimation of patient liability	Make sure the patient is really who the patient says they are. Validate patient's address, social security, and date of birth.	Payors require that certain procedures are pre-approved before performing. This service identifies those procedures that need to be pre-authorized / approved.	Checks the patient orders against rules to determine if the service is medically necessary. For Medicare if procedures is not covered then an ABN (Advance Beneficiary Notification) must be made so patient understands procedure is not covered.	Review and validation of all registration data to ensure that all data was captured accurately during the process
Financial Impact	Verifying the patient's level of insurance determines how to collect payment from patient.	If no insurance is found, then put into appropriate workflow.	Reduce denial rates Payor will deny and not pay on a procedure that was not previously authorized per their rules.	Reduces denials by checking for orders that are likely to deny Reduces procedures that may not be reimbursed saving costs	If data is clean from patient access upstream then the likelihood of denial is reduced further down the process.

nthrive

Communication and Information are Key

- Start by acknowledging your organization has a denial problem
- Gather your organization's claim denial facts (initial denials thru denial write-off) and communicate to key stakeholders
- Establish a dedicated denial prevention and management committee that includes a defined executive sponsor and committee charter
- Engage committee members and assign accountability for resolution thru defined meeting cadence, resolution and report-out expectations

GETTING STARTED:
ACTIONABLE RECOMMENDATIONS

Know Your Data

- ✓ 60% of the UB claim form fields are populated using information gathered and entered by patient access/registration
- ✓ Assess/analyze existing data for various trends; Data trends identify opportunities for improvement (OFI)
- ✓ OFIs feed your action plans and support denial prevention efforts
- ✓ Baseline performance for all action plans and measure at defined intervals to demonstrate improvement or needed corrections to the action plan if needed
- ✓ Typically, 75% of denied dollars are attributed to inpatient encounters, and 25% to outpatient. Conversely, 25% of denied cases are inpatient, and 75% are outpatient.
- ✓ Tracking denied dollars and volume across all service lines helps narrow to specific OFIs.
- ✓ Trend denial data using multiple data dimensions, such as:
  - Payor or Plan Code
  - Denial reason
  - CPT, DRG or Revenue codes
  - Service location
  - Ordering/attending/discharging provider

Productivity Best Practices

- ✓ RECOVERY: Measure resolution actions – those tasks that specifically push the denial toward recovery
- ✓ RECOVERY: Clinicians craft 4-6 well written appeals per day (varies by case complexity); a clinical denial rep can process 25 resolution tasks per day; a technical denial rep can process 35 resolution tasks per day
- ✓ RECOVERY: Expedite recovery by contacting payor via phone to validate receipt of appeal and timing of next steps
- ✓ PREVENTION: Conduct quality assessment audits on at least 10% of all registrations, UR/CM activities, documentation and coding ensuring 98% or higher accuracy score
- ✓ PREVENTION: Consider expanding denials committee to a full-blown outpatient throughput committee that reviews the entire patient flow.
  - Include IT support who can help tackle technical denials needing system configuration changes to be made in the patient accounting system or other systems/technologies

KPIs

Business Value	Decrease write-offs	Reduce targeted denials categories	Increase overturn rate	Reduce cost to collect
Metrics	Write-offs due to denials, denials as % of NPSR	$ or % in top 10 denials categories trended over time	Dollar amount of denied accounts overturned and paid (fully or partially) divided by all denied dollars	Denials processing time or average cost of working a claim

DENIAL RATE

Benchmark: < 5%

Indicates organization's ability to comply with payor requirements and payor's ability to accurately pay the claim; efficiency and quality indicator

Calculation: Total # of denied claims/$ divided by total claims remitted (835 and paper)

DENIAL WRITE-OFFS AS % OF NPSR

Benchmark: < 1%

Indicates organization's ability to comply with payor requirement and payor's ability to accurately pay the claim

Calculation: Net denial write-offs divided by average monthly NPSR

AGED A/R

Benchmark: < 20% A/R = >90 days

Indicates efficacy in resolving accounts in a timely manner. As accounts age, the likelihood of collecting on them decreases.

Calculation: $ amount of A/R aged over 90 days divided by $ amount of total A/R

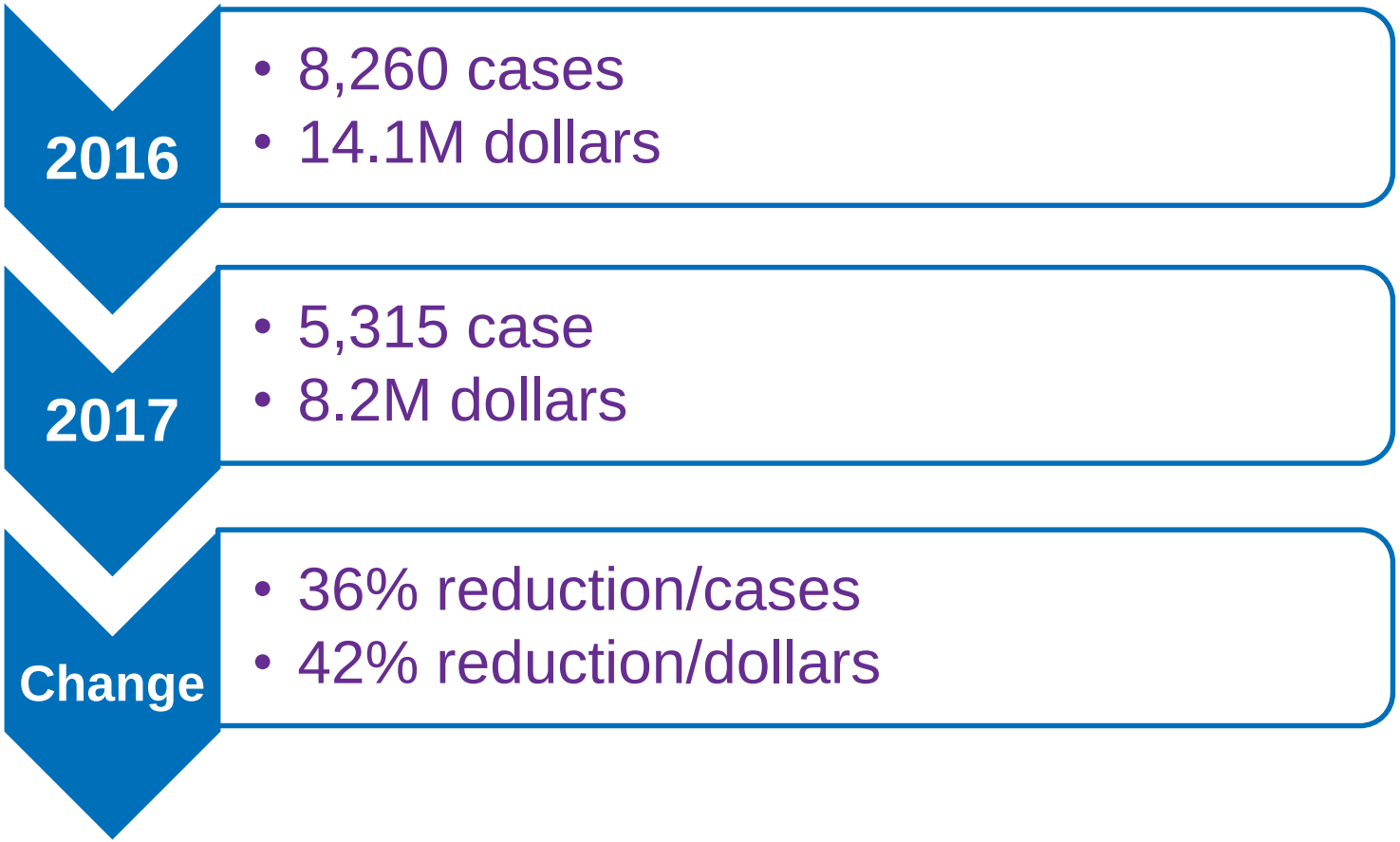
COST TO COLLECT

Benchmark: < 3% of cash

Measures expenses associated with collections, like transcription, coding and claims statusing, against revenue collected.

Calculation: Total revenue cycle cost divided by total patient service cash collected

Year-Over-Year Financial Impact of Denials Prevention Work Effort



Achieved by one nThrive client

Additional Wins from Denials Prevention Initiative

Process

Organization has begun communicating denials by reason code and financial impact to different departments every month

People

Buy-in has increased, and departments are realizing more ownership

Summary

Strategies:

- Look upstream
- Drill into data
- Have a plan
- Be persistent

The “Why”:

- Positively Impact Financials
- Increase Staff Productivity
- Improve Patient Experience

Thank you for your time today.