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Capturing Lost Revenue in the Deluge of Denials

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Path to Denial Prevention

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Agenda and Objectives

- Defining and standardizing “root cause”
- Identifying denial trends through root cause analysis and reports
- Identifying key stakeholders to own, develop and implement best practices to improve identified areas/issues
- Short & long term monitoring through evidence based KPIs
- Defining key components of a Denials Team
- Best Practices for Denial Management
- Denial Prevention Strategies
- Provide examples of Case Studies

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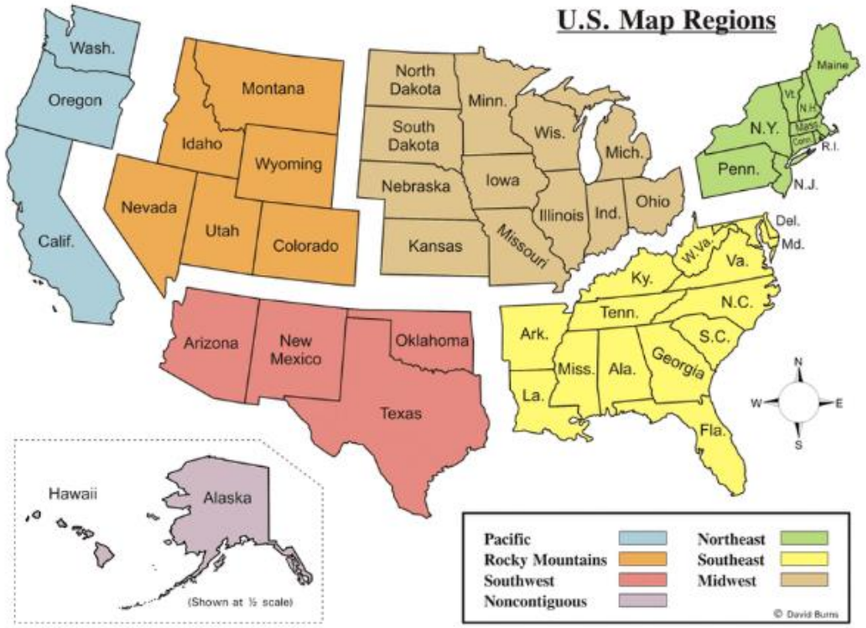
Claim Denial Rate

According to the **2020 Revenue Cycle Denials Index,** the average denials rate is up 23% since 2016, topping 11.1% of claims denied upon initial submission through the third quarter of 2020.

Below are the average claim denial rates for large hospitals, organized by geographic region.

- Northern Plains — 9.2%
- Mid-Atlantic— 7.3%
- Midwest — 9.7%
- Southern Plains — 10.5%
- Pacific — 13.1%
- Northeast — 12.9%
- Mountain — 6.7%
- Southeast — 7.4%



https://www.hfma.org/topics/news/2021/07/healthcare-news-of-note--national-index-shows-denials-are-up-11

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According to the Advisory Board:

There are 3 primary tools used by payers thereby increasing the volume of denials:

Automated Reviews

Algorithms used to downgrade DRGs

Billing errors

Coding Errors

Complex Criteria

Payer-specific Guidelines

NCDs/LCDs

State Requirements

Contract Requirements

Technical Requirements

Medical Policies

https://advisory-prod.azureedge.net/-/media/project/advisoryboard/shared/research/flc/success-page/2018/the-state-of-denials

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Revenue Cycle Pain Points

Front-End

Eligibility

Registration

Payer Notification

Authorization

Mid-Cycle

Documentation Issues

Medical Necessity

Delays in Procedures or Treatments

Discharge Planning

Physician Advisor/UR Team Skills Set

End-Cycle

Clean Claim Submission

Coding Issues

Payer Requirements

Timely Filing

Disparate Systems/Processes

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Defining and Standardizing Root Cause

Critical to develop and define each root cause category, with relatable examples.

- 1st level – broad, typically assigned based on CARC/remark code/835 Remittance Files
- 2nd level – detailed, typically assigned based on review of all available information internally and from carrier

- Scalable, continuous training of any associate who will be applying the root cause to a denial

- Ensure there is as little cross-over between root cause categories as possible

- Visibility into denials data real-time (decrease time to denial resolution)

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Identifying Denial Trends Through Root Cause Analysis

All reporting should reflect both dollars and volume of accounts

Review Upstream at the beginning of the revenue cycle

- Upstream Issues: scheduling, patient access, care delivery system

Middle Revenue Cycle Process Review

- HIM, Coding, and CDI play integral role in clinical documentation improvement

Real-time analytics

- Coding Audits
- Charge Capture
- Charge Master review
- Authorization issues

Deep Dive Analysis Capabilities

Standardize denial mapping by payer

- Denial Rate (Volume and Dollars)
- Overturn / Success Rates (Volume and Dollars)
- Denial Root Causes (Volume and Dollars)
- Write Off Rates (Volume and Dollars)

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Denial Root Cause Examples

Top 2 Reasons by Payer

Discharge Year 2021

Top 2 Reasons by Payer		
Payer	Reason	Dollars Placed
Aetna	Authorization	$452,478
	Medical Necessity	$333,514
Aetna Mgd Medicare	Medical Necessity	$2,384,446
	Non-Covered	$442,549
Anthem	Authorization	$1,557,494
	Medical Necessity	$1,428,750
Anthem Mgd Medicare	Medical Necessity	$2,374,057
	Authorization	$446,974
CareSource	Authorization	$4,410,994
	Medical Necessity	$2,707,486
Medicare	Medical Necessity	$611,439
	Authorization	$267,636
MMO	Medical Necessity	$2,386,194
	Authorization	$1,603,187
United Health Care	Medical Necessity	$3,182,582
	Authorization	$1,011,629
Top 2 Totals		$25,601,410

Discharge Year 2022

Top 2 Reasons by Payer		
Payer	Reason	Dollars Placed
Aetna	Medical Necessity	$74,166
	Authorization	$25,468
Aetna Mgd Medicare	Medical Necessity	$577,366
	Non-Covered	$141,268
Anthem	Medical Necessity	$410,555
	Authorization	$266,260
Anthem Mgd Medicare	Medical Necessity	$252,936
	Authorization	$50,543
CareSource	Authorization	$609,724
	Medical Necessity	$555,196
Medicare	Medical Necessity	$82,700
	Authorization	$29,648
MMO	Medical Necessity	$372,891
	Authorization	$162,756
United Health Care	Medical Necessity	$514,721
	Authorization	$133,286
Top 2 Totals		$4,259,483

Drill down Root Causes: Medical Necessity and Authorization

	2021		2022	
Root Cause: Medical Necessity	No. Of Accts.	Dollars Placed	No. Of Accts.	Dollars Placed
Not Medically Necessary	1897	$10,035,328	267	$1,156,805
NCD/LCD	840	$6,498,104	97	$701,416
Level of Care	910	$1,786,621	206	$393,211
Experimental/Investigational	764	$2,325,821	82	$210,283
IP Criteria Not Met	5	$27,454	2	$33,810
All Other Medical Necessity	19	$63,990	0	$0
Grand Total	4435	$20,737,318	654	$2,495,525

	2021		2022	
Root Cause: Authorization	No. Of Accts.	Dollars Placed	No. Of Accts.	Dollars Placed
Authorization Not Obtained	2924	$10,761,998	463	$2,031,165
Client was informed No Precert Needed (NPN), is required	590	$5,622,782	123	$1,481,265
Payer Error	670	$6,049,206	161	$1,370,736
Authorization Coding Conflict	438	$4,161,989	91	$911,268
Authorization Obtained, Not Listed on Claim	200	$1,780,057	60	$643,556
DOS Conflict	151	$972,642	43	$436,398
Partial Authorization Obtained	247	$1,253,940	46	$302,091
All Other Authorization	902	$6,586,571	187	$1,110,780
Grand Total	6122	$37,189,184	1174	$8,287,260

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Action Plan: Identifying Key Stakeholders

- Mix of experience and outside eyes, thinkers and doers
- Authority to make and implement changes
- Ability to test hypotheses and document results
- Set objectives and goals with deadlines and check-ins
- Communicate and begin implementation of best-practice to improve or fix identified area
- Set up standing meetings to review and summarize success of initiative/needed follow up

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KPI-based Short & Long Term Monitoring

- Business Intelligence, Analytics, Dashboards, Scorecards
- Establish measurable benchmarks and goals
- Review at intervals, starting frequently (daily/weekly) and then if successful moving to monthly/quarterly
- Audit to ensure “false positives” do not exist
- Engage other areas as needed
  - i.e. managed care
- Continuous improvement of reporting data

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Strong Case Management Program

- Clinicians with Revenue Cycle knowledge
- Advanced carrier criteria knowledge
- Patient status verification
    - Clinical presence in the ED
        - Real time information related to patient condition
        - Clinical documentation continuous reviews
- Specialized department for correct status verification
        - Centralized area that services all network facilities
- IP only procedures
        - Surgery scheduling

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Strong Case Management Program, *continued*

Ongoing Case Management review throughout admission

- For appropriateness of continued stay
- Avoidable days- delays in treatments/services
- Confirmation that patient meets discharge parameters
- Clerical staff to confirm-
  - that carrier received clinicals
  - approval vs denial, follow up accordingly
- Collaboration with physician advisor (Peer to Peer)

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Physician Advisor

For disagreements in patient status:

- The Attending Physician ⟷ Case Management
- The Attending Physician/Case Management ⟷ Carrier

For peer to peer reviews with payer:

- When Attending Physician unable/unwilling to have peer to peer
- Related to initial status and/or continued stay

For ongoing education of medical staff related to patient status criteria

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Denial Prevention ➡ Denial Management

Now that we have a plan in place to prevent denials in the future, what about the denials I have right now?

Even an impeccable denial prevention plan will not *eliminate* denials, so denial management remains a key concern.

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The Denial and Appeal Team

Either insourced or outsourced

Strong clinical representation with experience in:

- Revenue Cycle
- Interqual, MCG, NCDs, LCDs, payer medical policies
- Knowing when to use which criteria or policy
- Payer Contract
- Regulatory Guidelines (CMS)

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The Denial and Appeal Team

Analysts and clerical staff that can support clinical staff

- Allows nurses to focus on clinical analysis and clinical appeals

Legal input on denial team when needed

- Contract issues
- Statute involvement
- Assist with letter format and wording for increased effectiveness

Staff skilled at conducting root cause analysis of the denial (Data Team)

Multidisciplinary Departmental Collaboration

- HIM/Coding
- CDI
- Case Management/Social Work
- Registration/Patient Access
- Revenue Integrity/Charge Master
- Physician Advisor/Medical Director
- Executive Leaders

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Denial Management Tips

Know Your Contract

- Denials for no authorization
  - Does contract allow for review based on medical necessity?
- What are your appeal time limits?
  - Flexibilities in Timely Filing
- Have input and support from Managed Care Team
  - JOC Meetings
  - Payer Monthly/Quarterly Meetings to Address Trends
  - Address Payer Delays in processing claims/appeals/payments

Know Your State Statutes

- Fully vs. self funded plan?
- Does statute allow a longer appeal limit?

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Review Your Provider and Billing Manuals for Relaxed Time Limits.

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Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations, or claim disputes must be received within 180 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180 day timeframe unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1) A catastrophic event that substantially interferes with normal business operation of the provider or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by Ambetter or the Federal and/or State regulatory body.

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Denials are often inappropriately upheld after following carrier's appeal process

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Know Your Options

Must be able and willing to escalate improperly upheld denials

- Having the right knowledge on the Appeals Team allows proper/strategic escalation
- Criteria for Escalation

Escalation Process:

Escalate to the Carrier/Provider Representative

- Follow arbitration process

External Appeals- know the escalation process in your area

- Department of Insurance, Maximus, other

Referral to Internal Legal Team for possible legal action

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Line-Item Denials

What are Line-Item Denials?

- Charge Master denials in efforts to reduce reimbursement
- Denials issued post IB (itemized bill) reviews

Know the definition of billed charges in the contract

Modify payer-contracts to protect from these denials

- CDM Contract Language

Review Charge Master

- Reallocate charges to Room and Board when reasonable
- Implement coding updates and new guidelines to be more compliant

Follow appeal process

- Timely appeals
- Exhaust appeal levels
- Use Escalation Process

Dispute from a legal perspective

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Sample Denial Prevention Case Study

OVERVIEW

Large health system with 10 hospitals and multiple freestanding facilities

- Identified areas of improvement needed – OP Authorization and IP Medical Necessity Denials
- Root cause denial tracking implemented by encounter location (ED, SDS, Cancer Center, etc…)
- Root cause denial tracking implemented by payer and discharge date
- Case studies highlighting fail points on inpatient admissions
- Focus groups created to resolve discovered fail points

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Sample Case Study

Admission Detail	Clinical Summary	Auth/Denial Detail	Root Cause Analysis and Suggestions	Appeal/Outcome
Patient: Case Study #1 **Admission:** 8/1/19 (Saturday) **Discharge:** 12/28/19 (Monday) **LOS:** 150 days **Payer:** Simply **Total Charges:** $845,811.02 **Paid Amount:** $85,325.37 **Underpaid:** $21,418.88	**EMR:** 45M admitted 8/1 due to episodes of coffee-ground emesis, weakness and fatigue. Hx: SAH, quadriplegia, intestinal congenital atresia, short bowel syndrome, bowel resections, ESRD, PEG/J, partial blindness. 8/1 to 11/28 continued with vomiting req feeding adjustments and TPN, azotemia, fluid overload, electrolyte imbalances, blood transfusions, uncontrolled HTN with med dosage adjustments, hypotension, Klebsiella bacteremia, IV antibiotics, severe metabolic acidosis, hypothermia, worsening encephalopathy. Complications – mechanical vent then trach due to resp failure. DC to LTAC with trach collar on 12/28/2019. **Delays/Avoidable Days:** 9/2/19 to 9/4/19 Delay in Trach placement. OR scheduling and MD issues due to Holiday. 11/12 to 11/28 (16 days) – delay in discharge	**Facility Auth Detail:** • **Authorization facility obtained:** Auth 676642 was approved per D. Ramos, only valid for 8/1/19 to 12/5/19 • **ACM Documentation:** 12/5/19 Auth#676643 still open & approved per Onsite Reviewer. Patient meets IP • **Criteria used by Facility/findings**: Interqual **Payer Denial Detail:** • **Service denied by payer:** Days denied for no medical necessity • **Denied dates**: 12/6/19-12/28/19 • **Denial correspondence from payer:** EDM shows denial letter from Simply scanned 12/15/19 for continued stay/no med nec • **Criteria Payer Used to Deny:** MCG	**BLS Findings:** Pt met Interqual criteria for IP throughout stay- Acute-Infection Systemic **Fail Points:** 1) Copy/paste of progress notes 9/6/19 by Dr. Sean 2) Copy/paste of physician progress notes on 8/10/19 to 8/17/19 by attending physician 3) Payer utilizes MCG and also incorrect Interqual subset selected 4) Gaps in communication with onsite related to denial and attempt to schedule peer to peer 5) Denial Letter not sent to appropriate CM department **Suggestions:** 1) Contact Onsite Reviewer – Identify communication gap 2) Submit copy/paste examples to Medical Director/UR Steering Committee 3) Seek Medical Director facilitation in ensuring peer to peer discussions take place 4) Track/trend denials by CM and create education plan 5) Interqual and MCG continuing education and potential certification 6) Consider dedicated area to process and follow up on all concurrent clinical submissions and denials/NOAs	**Appealed?** Yes **Date Appealed: 1/5/2020** **Appeal Outcome:** Denial overturned in full **Date of Appeal Outcome:** 2/18/2020 **Post Appeal Paid:** $21,418.88 **Adjusted Amount:** $0

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Fail Points Identified

Copy/paste of physician progress notes

- Follow up by Medical Director/UM Steering Committee

Incorrect InterQual subset selection and criteria tool used

- Education plan implemented
- QA Reviews of Staff

Gaps in communication with onsite related to denial

- Meeting with onsite to identify/resolve communication gaps

Denial letter not sent to appropriate CM department

Carrier offered Peer to Peer but attending was unavailable

- Physician advisor was implemented to cover P2P when attending was unavailable.

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Fail Points Identified Case Study #2

Commercial Carrier had released a policy update limiting certain drugs to a site of care provision

- Initial dose was allowed and authorized at hospital-based facility, but subsequent doses were to be done in freestanding ASC or via home infusion (with some exceptions based on patient tolerance)
- Provider did not have a mechanism to catch subsequent doses, therefore drugs were being dispensed and denied for site of care
- Focus group implemented a flag for the affected J-codes, and alternate arrangements were made for patients who did not qualify to receive the drug in a hospital setting.

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Fail Points Identified Case Study #3

Two commercial carriers who used independent parties for authorization reviews were denying claims in error due to a linking issue in their system

- The IP was authorizing the service, granting an authorization number, but failing to transmit/communicate the approval to the health insurer
- Claims were being billed with the approved authorization numbers from the IP, however then denying for no authorization with the payer
- Focus group worked with managed care to initiate discussion with the payer. Payer agreed to retro-review the affected claims and re-adjudicate for payment with interest

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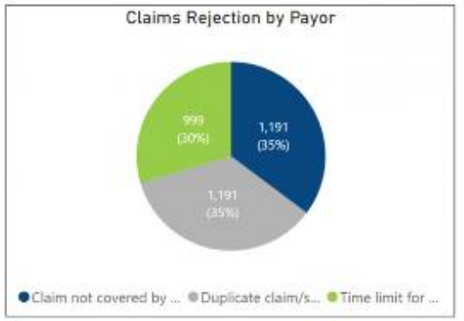
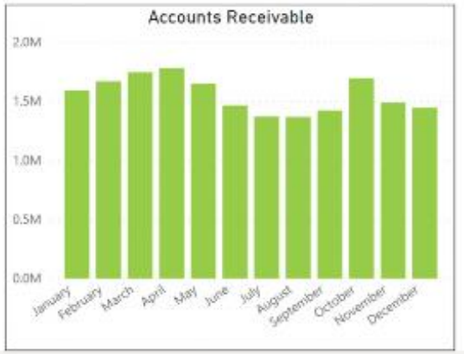
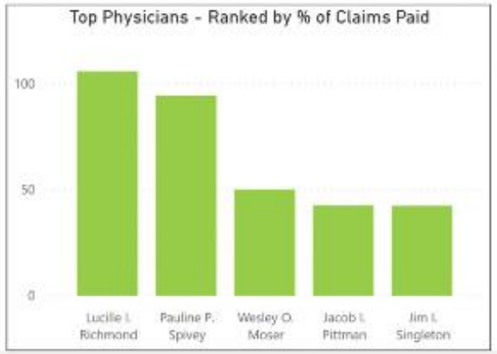
Payer Scorecards

KPIs to Increase Visibility

- Accounts Receivable Management
  - Aging A/R
- Denial Rates
- Overturn Rates
- Denials by Reason/Root Cause
- Percent of Payment Variance vs Revenue
- Cost to Collect
- Turnaround Times
  - Claim to payment
  - Appeal Aging







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Results

Root Cause	2018	2019	Comparison
Detailed Root Cause (A)	$9,148,413	$2,949,302	$(6,199,111)
Detailed Root Cause (B)	$1,052,914	$515,960	$(536,954)
Detailed Root Cause (C)	$968,788	$318,014	$(650,774)
Detailed Root Cause (D)	$620,354	$262,624	$(357,730)
Detailed Root Cause (E)	$522,942	$227,237	$(295,705)
Detailed Root Cause (F)	$667,887	$33,473	$(634,414)
Total Dollars (Anthem Authorization Denials)	$12,981,298	$4,306,610	$(8,674,688)

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Best Practices for Denial Prevention

Thorough tracking and trending of denials

Root cause analysis is done consistently and used in order to allow improvements from the front to end of the revenue cycle process

Denials Prevention and/or Resolution team with key individuals and skills set

Addressing denials from an organization-wide approach with heavy consideration of how financial and clinical factors intersect

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Q&A

THANK YOU

for the collaborative discussion today.
If we can help in any way,
please don't hesitate to contact us.

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