Managing and Preventing Denials in a Clinically-Driven Revenue Cycle

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Goals for our time together today

- Discuss Terminology
- Cost of Denials and increasing risks
- Charge Capture/Self-denials
- Managing Denials
- Rejection Prevention

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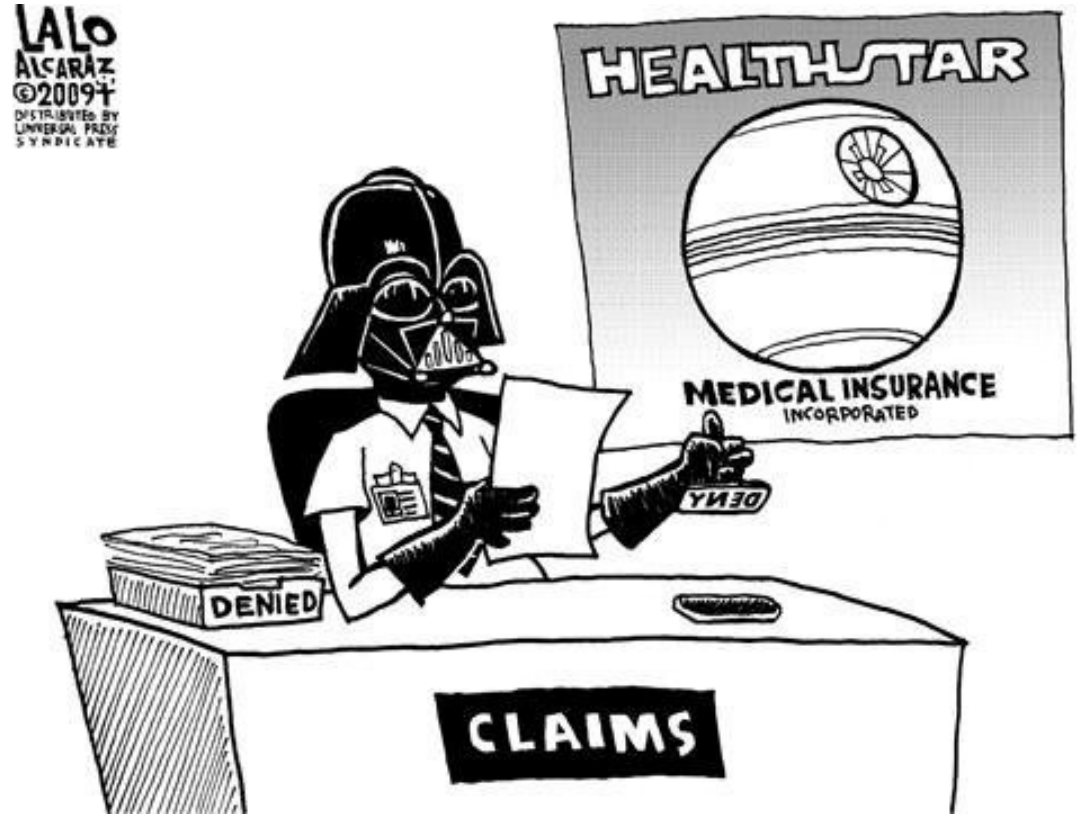
The REAL industry overview and market trends



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Definition of *denial*

1 : refusal to satisfy a request or desire
// the *denial* of privileges

2 **a** **(1)** : refusal to admit the truth or reality of something (such as a statement or charge)
// their *denial* of the divine right of kings

(2) : assertion that an allegation is false
// her *denial* that she was involved

b : refusal to acknowledge a person or a thing : DISAVOWAL
// his *denial* of his youngest son

3 *law* : the opposing by the defendant of an allegation (see ALLEGATION sense 2) of the opposite party in a lawsuit
// their *denial* of the plaintiff's allegations

4 : SELF-DENIAL
// ... a man in *denial* about his receding hairline.
Playboy

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Denials Defined

- The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional https://www.healthinsurance.org/
- Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided. (HFMA)

-Where we paid what was owed?

Vernacular of Denials Management

Hard Denial

Appeal required

Denial resulting in lost/written-off revenue

OR

Soft Denial

Additional information needed

Temporary or interim denial

Potential for payment

Both types delay payment and typically require additional work

The Cost of Denials

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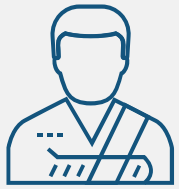
Revenue Cycle Funnel



Patient Need for Services

Scheduling

Registration

Clinical Events

Documentation

Charge Capture

Coding

Billing

Adjudication

$$Full / Accurate Payment$$

Inaccurate / No Payment

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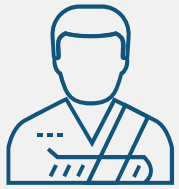
Revenue Cycle Funnel



Patient Need for Services

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$$Full / Accurate Payment$$

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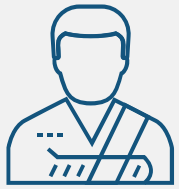
Inaccurate Payments Provides two options:

A. Rework

OR

B. Loss of Cash

Revenue Cycle Funnel



Patient Need for Services

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$$Full / Accurate Payment$$

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A. Rework

Cost of Rework:

- Rework costs average of **$25 per claim**[1]
- Success rates vary **from 55 to 98%**[2]
- Rework adds at latest **14 days to the average number of days** to pay[3]

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Reference: 1. (Leveraging Data in Healthcare: Best Practices for Controlling, Analyzing, and Using Data, by Rebecca Mendoza Saltiel Busch, CRC Press, 2016, ISBN-13: 978-1-4987-5773-7) **2.** (Leveraging Data in Healthcare: Best Practices for Controlling, Analyzing, and Using Data, by Rebecca Mendoza Saltiel Busch, CRC Press, 2016, ISBN-13: 978-1-4987-5773-7) **3.** (https://revcycleintelligence.com/news/overcoming-the-top-challenges-of-claims-denial-management-audits)

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Understanding the Industry Trend

$3 trillion

claims submitted

> $262 billion denied,

averaging almost **$5 million** per hospital

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

65% of claims denials are never re-submitted

The MGMA found only **35%** of providers appeal denied claim

31%

of hospitals manage denials manually

> 60% without an external solution

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

Impact of Denials Issue Extends Beyond Financial Results

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The Clinically Driven Revenue Cycle

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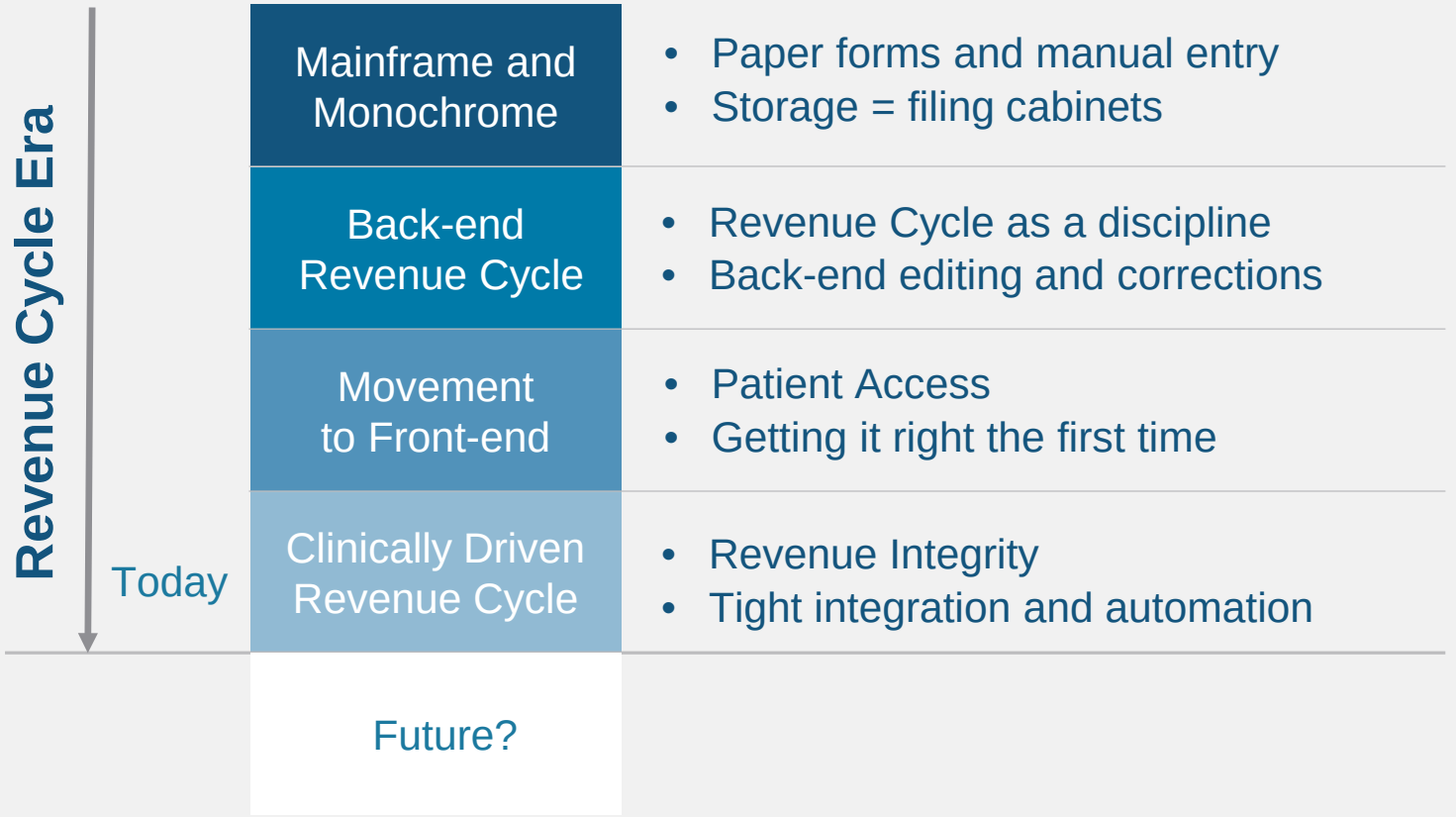
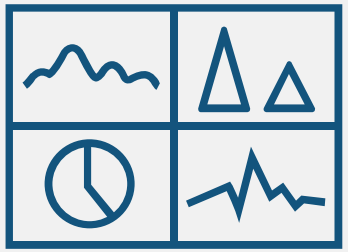
Revenue Cycle Evolution



Revenue Cycle Evolution



Clinically Driven Revenue Cycle

PAS/EMR are part of an integrated ecosystem

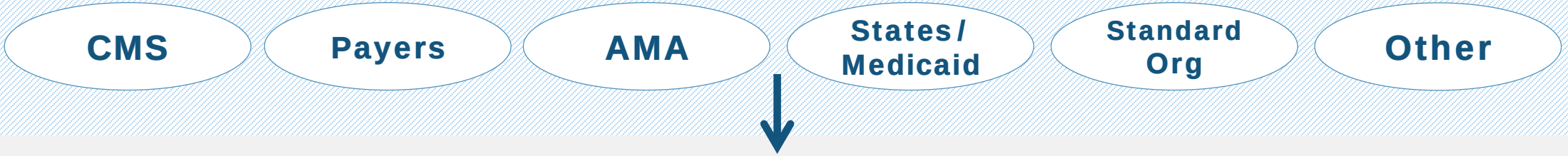
- Very Complex

The Clinical and Financial “Silos” are codependent

- Documentation, ordering and results trigger charges
- Patient care implications

Managing Changes in a Clinically Integrated Environment

Environment



Changes to Content

- Gather
- Normalize
- Assimilate/Deploy

Importance

- Compliance
- Revenue Improvement
- Expense Reduction
- Denials Prevention

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Root Cause of Denials is Multifaceted

Revenue Cycle Opportunities for Denial Prevention

Scheduling

- Eligibility/Member Cannot Be Identified
- Benefit plan coverage
- Benefit maximums exceeded
- 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 (Missing or Wrong Modifiers)

Billing / Collection

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

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Clinical Integration Adds More Complexity

Self-Denials

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"I GAVE IT A HEALTHY DOSE OF DENIAL, BUT IT DIDN'T HELP."

Self-Denials: The Importance of Charge Capture

Improves financial performance

Perception: Charges don't "matter" in a value-based payment environment (case rate, DRG, etc.).

Reality: Charge-based reimbursement is far from gone and still an important portion of hospital revenue cycle.

REAL IMPACT

"Identifying and correcting missed trauma charges in our Emergency Department had a greater than $2M impact to the bottom line in the first year."

– Director of Revenue Integrity at a 520-bed urban acute care hospital

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Self-Denials: The Importance of Charge Capture

Integral component of patient satisfaction

Perception: Patients with any coverage do not care about the itemized bill.

Reality: Denials Can / will impact a patient.

REAL IMPACT

- No one wants a bill that their insurance should have covered:
  - Registration Errors
  - COB Issues
  - Other
- Timeliness of patient bills can be impacted by denial problems

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Self-Denials: The Importance of Charge Capture

Compliance:
Accurate charge capture and accurate coding are tied together

A comprehensive Charge Capture Program prevents denials and compliance risks

Federal and State Authorities	• Office of the Inspector General • Department of Justice • Centers for Medicare & Medicaid Services • Office of the State Attorney General
Anti-Kickback Statute	**Pennsylvania False Claims Act**
Federal False Claims Act	**Beneficiary Inducement Law**
“Stark” law: Physician self-referral law	**Mail Fraud**

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Denial Management

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Denials Are Complex to Manage

- Resource and expertise intensive
- Denial information provided by third-party payers is not standardized
- Perceived inability to capture the denial data
- Constantly changing information
- Requires coordination throughout the revenue cycle
- Challenging appeals process

Rejection Prevention Measurements

HFMA MAP Keys

- Initial Denial Rate- Zero Pay
- Initial Denial Rate- Partial Pay
- Denials Overturned by Appeal
- Denial Write-offs as a Percent of Net Revenue

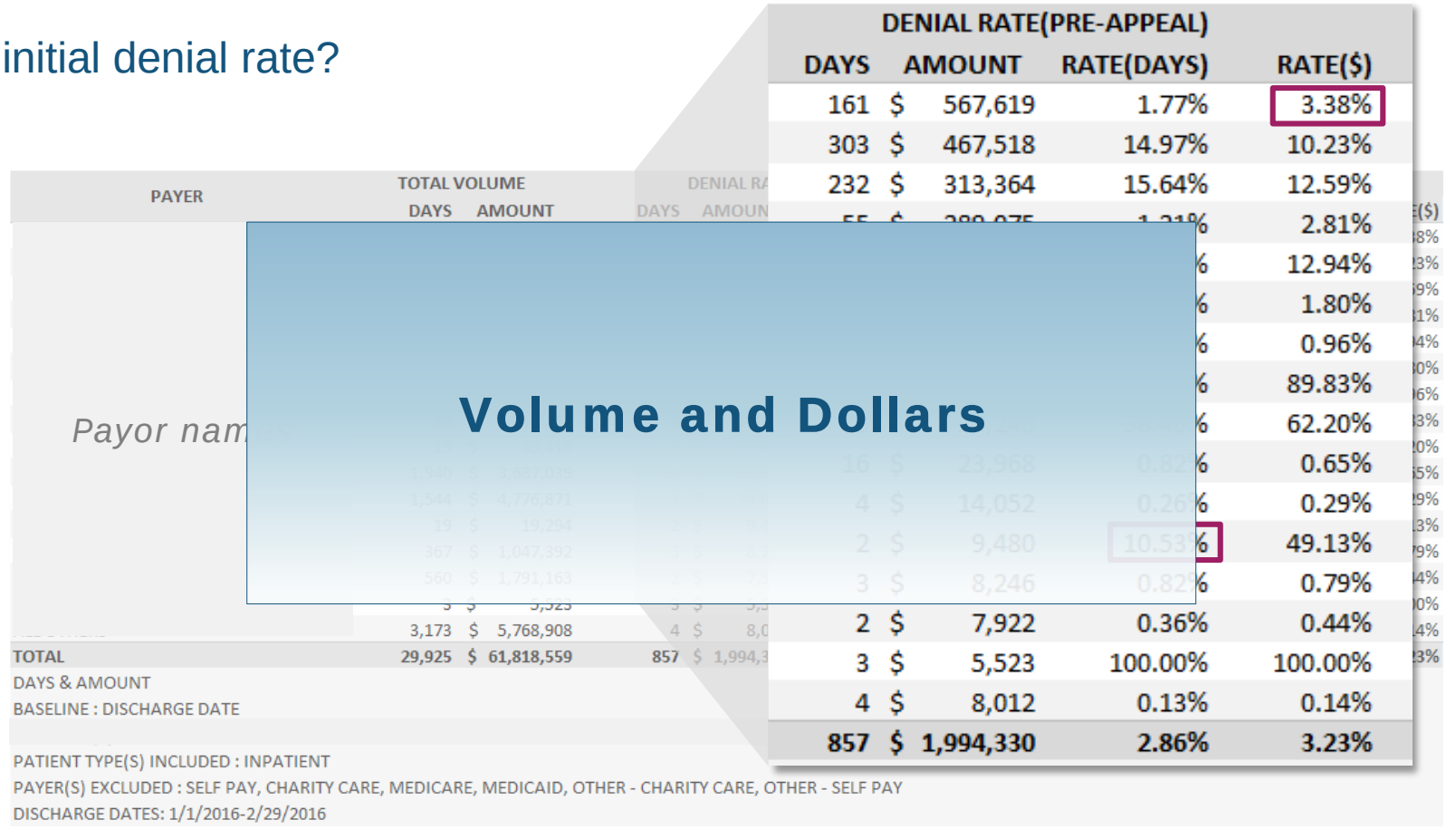
Report and Trend

- Total
- By Payer
- By Service Line
- By Reason

No metric or KPI is meaningful by itself!

Write-off review does not answer the important operational questions

What is your initial denial rate?



PAYER	TOTAL VOLUME DAYS	TOTAL VOLUME AMOUNT	DENIAL RATE(PRE-APPEAL) DAYS	DENIAL RATE(PRE-APPEAL) AMOUNT	DENIAL RATE(PRE-APPEAL) RATE(DAYS)	DENIAL RATE(PRE-APPEAL) RATE($)
Payor nam			161	$ 567,619	1.77%	3.38%
			303	$ 467,518	14.97%	10.23%
			232	$ 313,364	15.64%	12.59%
					%	2.81%
					%	12.94%
					%	1.80%
					%	0.96%
					%	89.83%
					%	62.20%
			16	$ 23,968	%	0.65%
			4	$ 14,052	%	0.29%
			2	$ 9,480	%	49.13%
			3	$ 8,246	%	0.79%
	3,173	$ 5,768,908	4	$ 8,0	2 $ 7,922 0.36%	0.44%
TOTAL	29,925	$ 61,818,559	857	$ 1,994,3	3 $ 5,523 100.00%	100.00%
					4 $ 8,012 0.13%	0.14%
					857 $ 1,994,330 2.86%	3.23%

Volume and Dollars

DAYS & AMOUNT
BASELINE : DISCHARGE DATE

PATIENT TYPE(S) INCLUDED : INPATIENT
PAYER(S) EXCLUDED : SELF PAY, CHARITY CARE, MEDICARE, MEDICAID, OTHER - CHARITY CARE, OTHER - SELF PAY
DISCHARGE DATES: 1/1/2016-2/29/2016

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Write-off review does not answer the important operational questions

What is your rate of appeal?

BALANCE:
You lose 100% of the denials you do not fight
vs. using resources
to fight a lost cause

			Grand Total	
Denials Appealed	Not Resolved	Outstanding	13,708	$73,814,392

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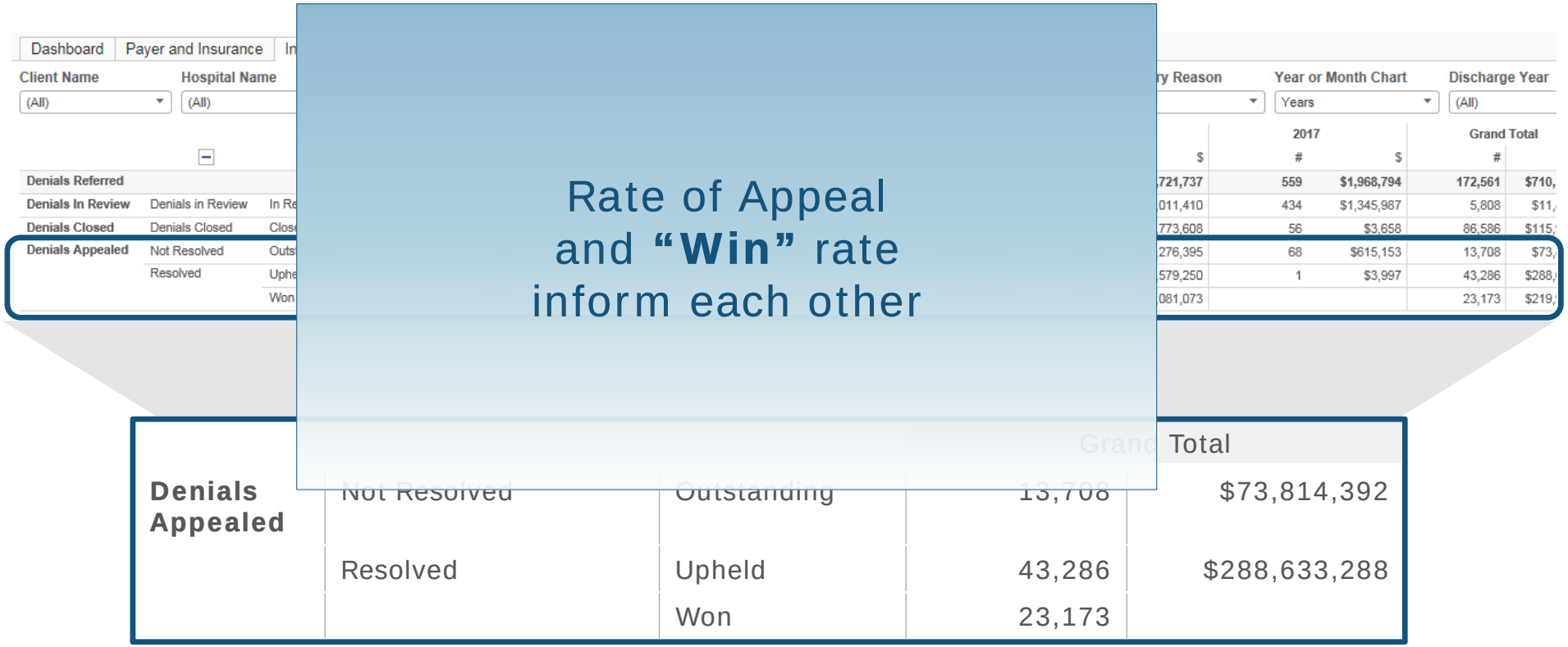
Write-off review does not answer the important operational questions

How effective are you?



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Write-off review does not answer the important operational questions

What is your cost to recover?

Appeals are the **MOST** expensive and longest way to collect what you are rightfully owed

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Rejection Prevention

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Rejection Prevention

- Goal is to move away from working denials to systemically preventing them
  - Beyond Bill Scrubbers and PAS Edits

- Recognize that eliminating 100 percent of denials is not possible
  - Continually improve and drive down top reasons
  - Small improvements can drive large financial results

- Proactive vs. reactive
  - Denials task force
  - Payor engagements
  - Root Cause

Create transparency into root cause

Denials are not addressable without understanding of root cause

- Managers and analysts need actionable data
- Reports must by timely
- Visibility is needed across the revenue cycle

Resulting Business Issues

- ✓ Limited access to up-to-date performance metrics
- ✓ Inability to diagnose performance bottlenecks
- ✓ Increased time to denial resolution

Normalize Data and make it meaningful

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

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

Bunding?
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?

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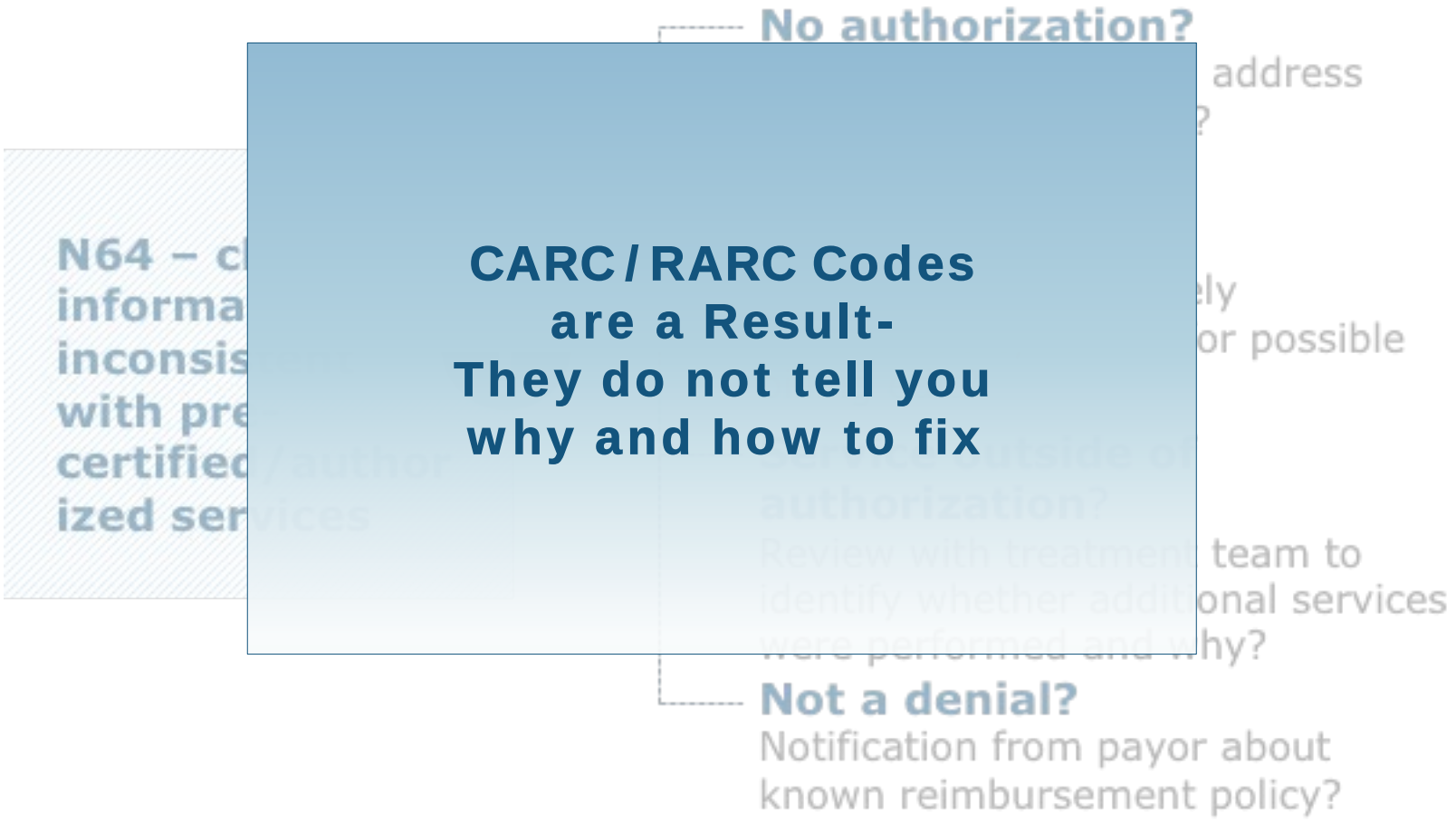
Normalize Data and make it meaningful



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Manage Payors

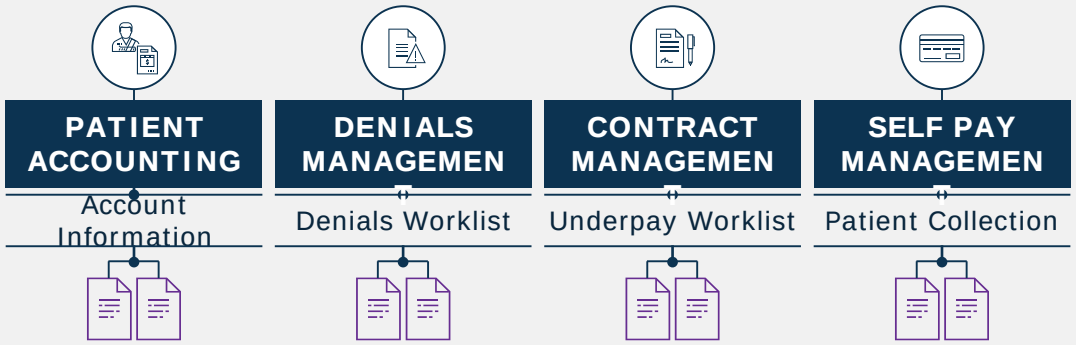
1. **Scorecards**
   - Information is power
   - Next contract
2. **Payor Websites and Notifications**
   - Access to updated policies and procedures
3. **Professional Groups**
   - Local Chapters are a great source of information
4. **Contract Protections**
   - Financial impact of policy changes
5. **Payor Relations**
   - Your representative needs to be part of your team

All Components are part of the comprehensive strategy to prevent denials

Connect disparate systems and processes and leverage technology

- Multiple disjointed IT Systems
- Inability to accurately identify denial root cause
- Inefficiencies routing accounts to the appropriate team

Typical Disparate Denials Technology



Resulting Business Issues

- ✓ Increasing AR days
- ✓ Write-offs to bad debt
- ✓ Lost revenue

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Connect disparate systems / processes and leverage technology

- Multiple disjointed IT Systems
- Inability to a
- Inefficiencies

Medical Necessity and Authorization and eligibility software

Claim Validation
- Upstream and Clearinghouse strategies
- Clean claim rate vs. denial rate

Normalized denial and adjustment codes across systems and reports

lting
ness Issues
easing AR days
e-offs to bad
revenue

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Create Governance, Ownership, and Accountability

- Denials avoidance requires significant effort across the revenue cycle. While two-thirds of denials are recoverable, 90% of denials are preventable.
- Without sustainable process improvement, technology and analytics alone will only provide a fraction of the possible results hospitals can achieve.

Resulting Business Issues

- ✓ Short-term results only
- ✓ Repeated denials without addressing underlying root cause
- ✓ Denials incidence remains unchanged

Create Governance, Ownership, and Accountability

Rejection Committee / Task Force:

Front-Middle-Back Representation (and Beyond)

- Revenue Integrity
- Managed Care
- Care Coordination
- Billing
- Coding
- Patient Access
- IT

Payor Feedback

Organizational Priority-Supported by Senior Leadership

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