THE DENIALS CHALLENGE
A Cross-functional Approach to Denial Prevention and Management

October 2017
Presenters

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△ Carmen Sessoms, FHFMA, Associate Vice President, RCM Advisory Services Program, Change Healthcare
The Impact of Denials
Carmen Sessoms, Associate Vice President, RCM Advisory Services Program, Change Healthcare
Denials: An obstacle to timely and complete reimbursement

$3 Trillion in Claims Submitted

$262 Billion
9% of Claims Denied

$4.9 Million
Per Hospital
3.3% Net Patient Revenue
Denial rates by region

- Pacific: 10.89%
- South Central: 10.5%
- Mid-West: 10.32%
- Southeast: 9.33%
- Southern Plains: 8.6%
- Northeast: 8.3%
- Mountain: 6.99%
- Northern Plains: 6.64%

Alaska: 10.89%
Hawaii: 10.5%
PR: 10.32%
VI: 9.33%
Pacific: 8.6%
Mid-West: 8.3%
Southeast: 6.99%
Southern Plains: 6.64%
Denial causes span the entire revenue cycle, although the largest percentage are associated with front-end processes.

- Registration/Eligibility: 23.9%
- Missing or Invalid Claim Data: 14.6%
- Auth/Pre-Cert: 12.4%
- Medical Documentation Requested: 10.8%
- Service Not Covered: 10.1%
- Other: 9.6%
- Medical Coding: 5.8%
- Medical Necessity: 5.8%
- Untimely Filing: 3.7%
- Appropriateness of Care: 3.4%
Appealing denials is costly

63% of Denied Claims are Recoverable on Appeal

Appeals Cost Average $118 Per Claim

$118

Total Admin Costs $8.6 Billion
The Change Healthcare denials and appeals data was culled from a sample of more than 3.3 billion hospital transactions valued at $1.8 trillion.

Change Healthcare analysts used primary institutional inpatient and outpatient claims processed by Change Healthcare in 2016, and the average charged amount and first denied amount for the 724 hospitals included in the claims sample.

The total claimed charges and denied amounts for the nation’s 5,683 hospitals was then extrapolated from this sample data. An appeal success rate of 63%\(^1\) and average reimbursement rate of 29%\(^2\) were used to calculate the amount denied. The $118 per claim average appeal cost is based on Change Healthcare statistical averages for hospital customers.

The data used for the analysis is based on internal Change Healthcare data, and may or may not be representative.

1 Based on Change Healthcare statistical averages for hospital customers.
2 Based on Change Healthcare Pulse Revenue Cycle Benchmarking™ national average reimbursement rate.
Seven Denial Prevention Strategies
An analytics-driven revenue cycle enables a cross-functional approach to denial prevention.

Patient access  ➔  HIM  ➔  Billing / collection

Analysis and use of data
The first steps in denials prevention - analysis

1. Root Cause Determination

- Patient Access and Registration
- Insufficient Documentation
- Coding/Billing Errors
- Payer Behavior
- Utilization/Case Management

2. Prioritization

- Which has the greatest impact?
  - A certain physician
  - A particular service line
  - A specific payer
  - A certain type of code
  - A process redesign

Do you have this data? Is it accessible in a timely manner? Do you trust it?
3. Prevention strategy-eligibility

△ Do you check it consistently?

△ How often do you check it?
  • At scheduling
  • Three days before elective services
  • Day of service
  • During stay (interim billing)
  • Before submitting claim

△ If not eligible/covered, what is your process to inform patient of financial responsibility and other options?

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4. Prevention strategy – registration data quality

△ How are you alerted to potential data quality issues?

△ Are you applying business rules to examine registration data to help ensure it’s accurate, complete and consistent?

△ Are there workflows in place to correct errors in real-time?

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5. Prevention strategy – prior authorization and medical necessity

⚠️ Do you know the real reason your claims are denied for authorization?
   • Was it obtained?
   • Was it expired?
   • Was it for the wrong procedure?
   • Was the auth number not on the claim?

⚠️ Do you have the appropriate medical necessity business rules informing your process?

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Denial prevention starts in patient access

△ Secure Authorization

△ Identify Changes to Scheduled Procedures
  ▪ Ordered vs. performed
  ▪ Revised authorizations

△ Insurance Plan Changes
  ▪ Real-time eligibility
  ▪ Exchanges and unpaid premiums can lead to denials
  ▪ Coverage change with plan year changes
Denials prevention starts in patient access

- **Scheduling**
  - Require insurance, appropriate codes and authorization
  - Medical necessity
  - Record all calls and electronically capture digital image of authorizations from payer website

- **Authorization Team**
  - Verify payers authorization requirements and correct authorization (obtains auth for physician offices)
  - Record all calls and electronically capture digital image of authorizations from payer website
Denials prevention starts in patient access

- **Pre-registration**
  - Verify insurance eligibility and benefits, IP only and outpatient codes
  - Document in ADT
  - Record all calls and electronically capture digital image of authorizations from payer website

- **Registration – Walk in, Direct Admits and STATS**
  - Verify insurance eligibility and benefits
  - Medical necessity
  - Notify authorization team when needed
Denial prevention continues in mid-cycle

⚠️ UR/Case Management
- Updating clinical data for continued stay approvals
- Involve Medical Director when peer-to-peer is needed
- Validate medical necessity

⚠️ CDI Team
- Educate physicians on documentation issues that lead to denials.
Analysis drives targeted education to help prevent denials

Note: Goal based on 2011 KPIs.
Eligibility verification improvement and stabilization

![Graph showing trend over time](image)

### Eligibility Verification Counts (2017-2019)

<table>
<thead>
<tr>
<th>Category</th>
<th>2017-01</th>
<th>2017-02</th>
<th>2017-03</th>
<th>2017-04</th>
<th>2017-05</th>
<th>2017-06</th>
<th>2017-07</th>
<th>2017-08</th>
<th>2017-09</th>
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</thead>
<tbody>
<tr>
<td>Batch Count</td>
<td>884</td>
<td>784</td>
<td>734</td>
<td>725</td>
<td>662</td>
<td>823</td>
<td>781</td>
<td>727</td>
<td>790</td>
</tr>
<tr>
<td>Eligible Count</td>
<td>22,893</td>
<td>21,877</td>
<td>24,120</td>
<td>22,593</td>
<td>21,424</td>
<td>22,805</td>
<td>21,636</td>
<td>23,261</td>
<td>21,370</td>
</tr>
<tr>
<td>Ineligible Count</td>
<td>1,013</td>
<td>891</td>
<td>857</td>
<td>830</td>
<td>929</td>
<td>930</td>
<td>905</td>
<td>858</td>
<td>913</td>
</tr>
<tr>
<td>Payer Not In System Count</td>
<td>18</td>
<td>8</td>
<td>13</td>
<td>8</td>
<td>12</td>
<td>18</td>
<td>16</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Payer Unavailable Count</td>
<td>297</td>
<td>675</td>
<td>663</td>
<td>870</td>
<td>673</td>
<td>1,175</td>
<td>640</td>
<td>526</td>
<td>1,340</td>
</tr>
<tr>
<td>Unknown Count</td>
<td>5,763</td>
<td>5,225</td>
<td>5,537</td>
<td>5,246</td>
<td>5,891</td>
<td>5,523</td>
<td>5,289</td>
<td>5,196</td>
<td>5,139</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>30,848</strong></td>
<td><strong>29,410</strong></td>
<td><strong>31,964</strong></td>
<td><strong>30,272</strong></td>
<td><strong>28,701</strong></td>
<td><strong>31,274</strong></td>
<td><strong>29,259</strong></td>
<td><strong>30,895</strong></td>
<td><strong>29,564</strong></td>
</tr>
</tbody>
</table>
Registration quality improvement and stabilization

Ridgeview Medical Center
Pre- & Post-QA Registration Accuracy

Pre QA
Post QA
6. Prevention (and management) strategies – effective claims process

- **Strong Edits**: To help submit clean claims
- **Claim Visibility**: To enable proactive issue resolution
- **Appeal Denied Claims**: To help recover potential revenue
7. The last step, same as first...ongoing analysis across the revenue cycle
Regularly seek facts and implement change

- Seeks facts
- Seeks facts
- Invests in skills and technology
- Implements change
  - Implements change
Denial prevention in the claims process

⚠️ Patient Financial Services
- Build edits in your host system and/or claims scrubber
- Tailor edits to the payer

⚠️ Denials Team
- Involve the front-, middle- and back-end departments
- Track denials by payer, denial type, department, etc.
- Find the trends
- Focus on largest denials by volume and dollar
- Create focus groups with all departments involved to find and correct the root cause of denials
Appealing denied claims

△ Concurrent and Retrospective Denials

▪ Denial reviewed by clinical nurse reviewer for appeal decision
▪ Acceptance of denial; bill payer for outpatient, ED and ancillary services, as applicable
▪ Peer-to-peer (P2P) with payer for medical director or admitting physician if available
▪ Non-acceptance of denial; written appeal per payers’ guidelines
Appealing denied claims

- Appeal Process
- Education
  - Detailed review of all denials by denial management team
  - Provide education on steps to eliminate specific identified denials
  - Meet with departments monthly to review denials for their department and to collaborate on process improvements to eliminate denials.
### Managed Care

- Have your Managed Care/Contract department informed of issues
- Have regular meetings with payers on denial issues

### Denial prevention impacted by payer relations

<table>
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<tr>
<th></th>
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<tbody>
<tr>
<td>AK</td>
<td>Physician Assistant/Nurse Practitioner</td>
<td>Other</td>
<td>CO</td>
<td>A1</td>
<td>Claim/Service denied. At least one Remark Code must be provided (may be comprise</td>
<td>MINNESOTA MEDICAID</td>
<td>1500 – OP</td>
<td></td>
<td>$231.00</td>
</tr>
<tr>
<td>GB</td>
<td>Gastroenterology</td>
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<td>Medical Necessity</td>
<td>CO</td>
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<td>Treatment was deemed by the payer to have been rendered in an inappropriate or i</td>
<td>MINNESOTA MEDICARE</td>
<td>1500 – OP</td>
<td></td>
<td>$78.00</td>
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<td>SK</td>
<td>Behavioral / Mental Health</td>
<td>Other</td>
<td>CO</td>
<td>122</td>
<td>Psychiatric reduction.</td>
<td>MINNESOTA MEDICAID</td>
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Analysis of denial categories drives improvements

<table>
<thead>
<tr>
<th>Denial Category (hospital)</th>
<th>Percent Denied Charges</th>
<th>Denial Reason (clinic)</th>
<th>Percent Denied Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing or Invalid Claim Data</td>
<td>31.1%</td>
<td>Service not covered</td>
<td>21.9%</td>
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<tr>
<td>Other</td>
<td>24.1%</td>
<td>Medical Coding</td>
<td>20.1%</td>
</tr>
<tr>
<td>Registration / Eligibility</td>
<td>19.6%</td>
<td>Duplicate Claim / Service</td>
<td>19.0%</td>
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<td>Service not covered</td>
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<td>Duplicate Claim / Service</td>
<td>4.9%</td>
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<td>Medical Documentation Requested</td>
<td>4.3%</td>
<td>Other</td>
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</tr>
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<td>1.5%</td>
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</tr>
<tr>
<td>Authorization / Pre-Certification</td>
<td>0.5%</td>
<td>Medical Documentation Requested</td>
<td>2.2%</td>
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<tr>
<td>Medical Necessity</td>
<td>0.5%</td>
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<tr>
<td></td>
<td></td>
<td>Provider Eligibility</td>
<td>0.7%</td>
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# Denial category report for physician and payer scoring

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Cross-functional improvements impact final result

Denial Appeal Recovery Rate = 93%

- Fewer registration errors
- Fewer denials
- More effective appeal process
Technology and services can empower your revenue cycle priorities

**ENGAGEMENT & ACCESS**

- Patient Access
- Eligibility & Enrollment

**QUALITY OUTCOMES**

- Financial Counseling
- Clinical Docs Improvement

**REVENUE PERFORMANCE**

- Provider Coding & Audit
- Payment Automation

**OPERATIONAL EFFICIENCY**

- Missed Charges / Coverage
- Under-payment Audits

### RCM Analytics | Data Solutions

- Reg QA & Eligibility
- Pre-Auth & Med Necessity

- Estimation & Patient Payment
- Imaging, Workflow, and Care Solutions

- Patient Bills & Payments
- Claims Submission & Monitoring

**Network**

- Pre-Service
- Service
- Post-Service

- Value-Based Care Solutions
- RCM Services
- Physician Group Managed Services
- Consulting

**Software & Analytics**

- Pre-Auth & Med Necessity
Questions?

Compare your denial rate to peers. Visit the Revenue Cycle Index at myhealthyhospital.com