The “Right” Approach to Denial Prevention

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Healthy Revenue, Healthy Future

The Bottom Line is Better Care

Agenda

- The Denials Challenge
- Analysis Enables Strategic Action
- Revenue Cycle and Clinical Prevention Strategies
- Q&A
- Resources

Our Denial Challenges

1 in 5 Claims

Denied or delayed[1]

30-40%

Of denials are caused by registration errors[2]

3% net revenue loss caused by denials[3]

Impact

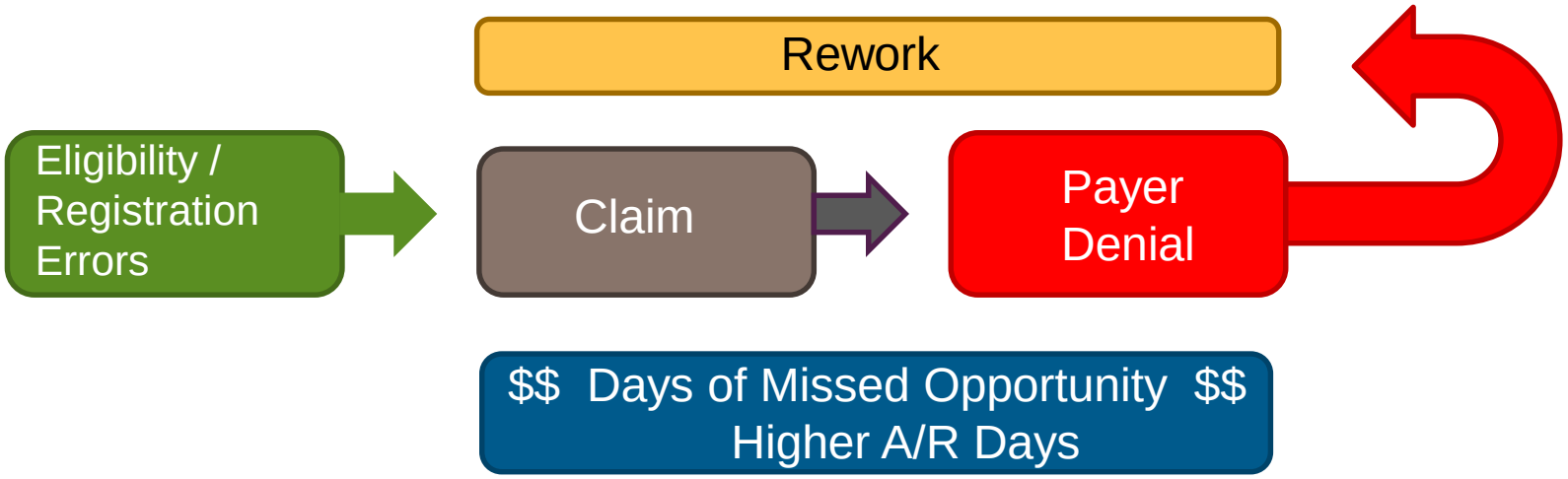
Denials are one of the most costly revenue cycle issues and greatest concerns to revenue cycle leaders

Sources:
[1]PNC Financial Services Group, Automated Billing/Payment Process Can Reduce U.S. Health Care Costs without Sacrificing Patient Care, November 2007
[2]HBI Academy Research, Registration Errors Significantly Impact Reimbursements
[3]Driving the Denials Management Initiative, a Renewed Focus, The Advisory Board Company, Washington, D.C., web conference, July 2009

The Costs Continue

20%

overall revenue cycle operating costs from claims rework*



*Steven Huddleston, “Creating a Healthy, Unified Revenue Cycle” *HFMA Revenue Cycle Strategist*, November, 2012

Where Do Most Denials Occur?

Denial Reason	National
Registration / Eligibility	28.0%
Duplicate Claim / Service	19.2%
Service not covered	15.0%
Missing or Invalid Claim Data	11.7%
Medical Documentation Requested	6.5%
Authorization / Pre-Certification	5.8%
Medical Necessity	5.4%
Medical Coding	4.3%
Untimely Filing	3.1%
Coordination of Benefits	1.1%

20%

of claims are denied[1]

$25

Cost to rework a claim[2]

Represents claims released to payers from January 2014 through October 2015 that were denied.
Only includes hospitals that process remits through RelayHealth Financial and have given RHF data rights.

1 http://www.poweryourpractice.com/revenue-cycle-management/highly-effective-medical-billing/:
2 http://www.hfma.org/Content.aspx?id=32086)

Denial Analysis Enables Strategic Action

Root Cause Determination

- Where are denials originating?
  - Patient Access and Registration
  - Insufficient Documentation
  - Coding/Billing Errors
  - Payer Behavior
  - Utilization/Case Management

Prioritization

- Which has the greatest impact?
  - A certain physician
  - A particular service line
  - A specific payer
  - A certain type of code
  - Process redesign in both the clinical and revenue cycle areas of opportunity

Armed with an analysis, you can begin to prevent denials more strategically

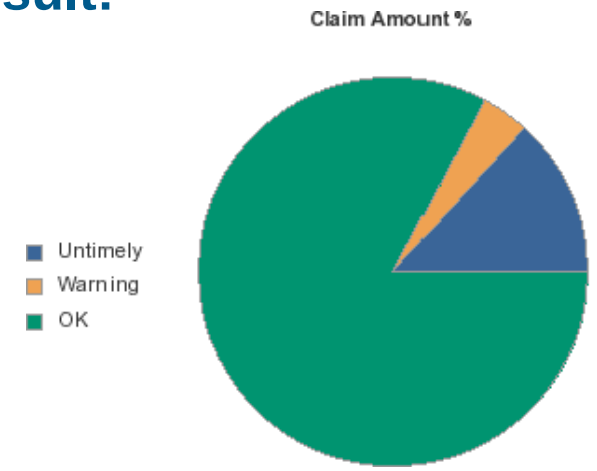
Drive Down Denials with Analytics

Who: 600+ bed hospital system in Southeast

Problem: Charges being denied by payers for Untimely Filing

Solution: Investigated how they were submitting claims from the HIS and fixed one issue. Created three timely categories to purge expired claims and monitor claims approaching the deadline to avoid future timely deadlines.

The Result: The value of future write-off savings is roughly **$2M**!



Timeliness Bucket	Total Claim Count	Claim Count %	Total Claim Amount	Claim Amount %
Untimely	866	12.6%	$7,840,562.95	13.4%
Warning	323	4.7%	$2,304,653.03	3.9%
OK	5,673	82.7%	$48,469,371.57	82.7%
Totals	**6,862**		**$58,614,587.55**	

Advance Warning Days = 30

Data source: RelayAnalytics™ Acuity

Prevention Strategies - Eligibility

Eligibility denials often occur when a payer is no longer responsible

Root-cause analysis may reveal that staff isn't performing a thorough eligibility verification

Confirm eligibility at scheduling, three days before elective visits, on the date of service, and before submitting the claim.

For emergency patients, check eligibility at POS

Contact patients who underwent unscheduled procedures within 24 hours

43%

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Prevention Strategies – Registration Errors

- **Revcycle success** starts at Registration
- **Apply business rules** to examine registration data to help ensure it's accurate, complete and consistent
- **Fix errors in real-time** workflow to prevent downstream denials

11.7%

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Drive Down Denials Upfront

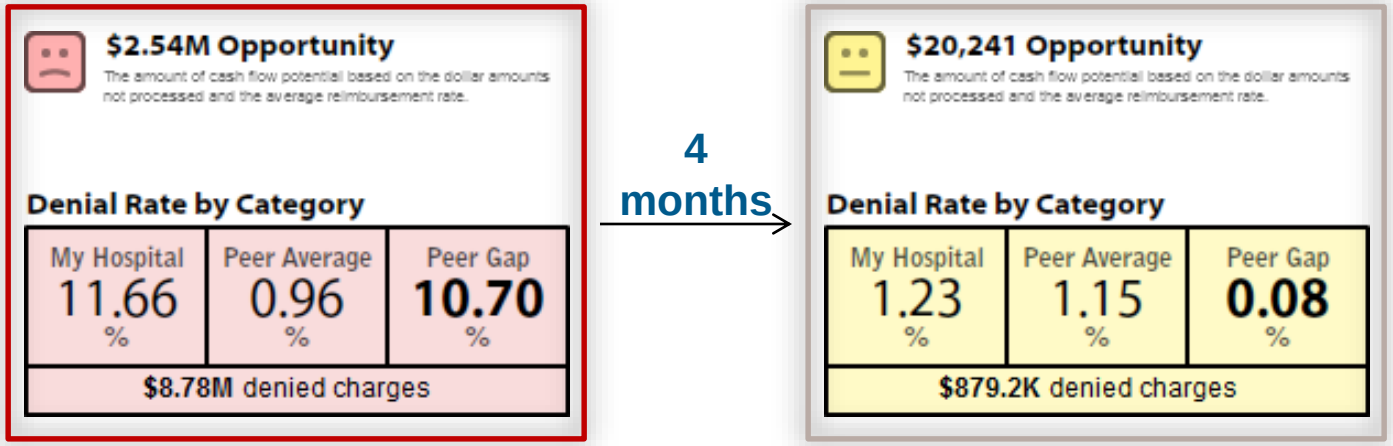
Registration and Eligibility Issues

Who: 600-bed health system in South

Problem: Needed to reduce its denial rate

Solution: Used data to understand extent and value of issues. Exposed **Registration/Eligibility** issues as a primary root cause of denials

The Result: Over four months, Registration/Eligibility Denial Rate plummeted from 11.66% to 1.23%. Cash value: **$2.4M**!



Prevention Strategies – Authorization and Medical Necessity

- **Denials** for Authorization and Medical Necessity **are costly**
- **Pre-auth issues** are usually due to:
  - Failure to secure the auth
  - Clinically-driven change in the procedure – most often the cause of chronic denials

11.2%

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Pre-Authorization Costs

Only 7%
of Authorization transactions are electronic
CAQH, 2016

Pre-registration staff spend up to 9 hours per FTE per week on hold with payers
-Large Florida Health System

Pre-Auth is Costly to both payers & providers **$35-105** per pre-auth
Internal McKesson Analysis

78%
Of physicians say eliminating Preauthorization hassles is "very important"
AMA Survey of Physicians, May 2010

Pre-Authorization Overview

U.S. Provider Cost of Payer Administration =
$31B
Health Affairs, May 14, 2009

$14
Average provider cost per manual Authorization
CAQH, 2016

Payer Perspective
1/3 of Knee Replacements not necessary
Arthritis & Rheumatology, June 2014

8% Overlap
in authorization requirements for **1300 procedures across 23** major health plans
McKesson Analysis, 2016

Prevention Strategies – Pre-Authorization

Defined pre-auth roles

Designated team should own the process to ensure a reliable and stable approach

Technology enabled process

Automate screening and verification embedded in workflow

Automate payer policy maintenance

Automate the location, capture and maintenance of payer auth policies

Definitive answers

Screening/verification automation provides definitive answers about whether a service needs pre-authorization

Denial Prevention & Management

Effective denial prevention happens throughout the entire revenue cycle

Billing / Claim Submission

- Efficient claims management process
- Comprehensive claim editing to improve first pass acceptance
- Validate claim for missing information and complete

Post Submission

- Monitor claim status for potential issues
- Submit appeals for initially denied claims
- Utilize analytics to conduct deep dive analysis into processes for strategic improvement

Managing Denials from a Clinical Perspective

Clinical Best Practices

- Present
- Not Present Consistently
- Focus Required

Visible Leadership and Clear Vision	ED Case Management Program	Effective Observation Management
Consistency of Process and Review Frequency	Dedicated Physician Advisor	Effective use of Evidenced Based Content
Effective Level of Care Management	Robust Clinical Documentation	Data Driven Program at the staff level

Strategies to Help Prevent Medical Necessity Denials

1. Ensuring medical necessity validated prior to every admission (ED, direct, transfers and elective admissions)
2. Ensure medical reviews are being conducted on admission and every couple of days during the hospital stay to address discharge planning gaps
3. Ensure evidenced based content is being used correctly
4. Ensuring documentation supports decisions made and level of care; educate physicians on the critical role they have in this key areas
5. Ensure nursing and other departments are equally invested in length of stay management
6. Ensure the medical review demonstrates holistic understanding of the patient with a clearly articulated medical and discharge plan

Q&A

Resources:

ReduceMyDenials.com – overall denial strategy resources

HealthyRevenueHealthyFuture.com – pre-authorization resources

DenyDenials.com - medical necessity resources

For More Info: 800-752-4143

