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 delayed¹

3% net revenue loss caused by denials³

30-40%

Of denials are caused by registration errors²

Impact

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

Sources:
¹PNC Financial Services Group, Automated Billing/Payment Process Can Reduce U.S. Health Care Costs without Sacrificing Patient Care, November 2007
²HBI Academy Research, Registration Errors Significantly Impact Reimbursements
The Costs Continue

20% overall revenue cycle operating costs from claims rework*

Eligibility / Registration Errors

Claim

Rework

Payer Denial

$$ Days of Missed Opportunity $$

$$ Higher A/R Days $$

*Steven Huddleston, “Creating a Healthy, Unified Revenue Cycle” HFMA Revenue Cycle Strategist, November, 2012
# Where Do Most Denials Occur?

<table>
<thead>
<tr>
<th>Denial Reason</th>
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<tbody>
<tr>
<td>Registration / Eligibility</td>
<td>28.0%</td>
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<tr>
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20% of claims are denied.

$25 Cost to rework a claim.

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Denial Analysis Enables Strategic Action

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

- 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.

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

Advance Warning Days = 30

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**Pie Chart:**
- Untimely
- Warning
- OK

**Table:**

<table>
<thead>
<tr>
<th>Timeliness Bucket</th>
<th>Total Claim Count</th>
<th>Claim Count %</th>
<th>Total Claim Amount</th>
<th>Claim Amount %</th>
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<tbody>
<tr>
<td>Untimely</td>
<td>866</td>
<td>12.6%</td>
<td>$7,840,562.95</td>
<td>13.4%</td>
</tr>
<tr>
<td>Warning</td>
<td>323</td>
<td>4.7%</td>
<td>$2,304,653.03</td>
<td>3.9%</td>
</tr>
<tr>
<td>OK</td>
<td>5,673</td>
<td>82.7%</td>
<td>$48,469,371.57</td>
<td>82.7%</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>6,862</strong></td>
<td></td>
<td><strong>$58,614,587.55</strong></td>
<td></td>
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**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.

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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

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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

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**Pre-Authorization Costs**

**Only 7%**
- of Authorization transactions are electronic
- **CAQH, 2016**

**78%**
- Of physicians say eliminating Preauthorization hassles is “very important”
- **AMA Survey of Physicians, May 2010**

**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**

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

**Pre-Authorization Overview**

**Payer Perspective**
- **$14**
- Average provider cost per manual Authorization
- **CAQH, 2016**

- **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.
Effective denial prevention happens throughout the entire revenue cycle

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

- 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

- 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