



3MSM Health Care Academy

Don't just manage payer denials, prevent them

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Agenda

- Payer trends in healthcare – the real impact
- The entire revenue cycle as an opportunity for denials
- Best practices for improving a hospital's revenue cycle
- Moving from denials management to rejection prevention
- Understanding your organization – performing assessments
- Creating an action plan for a successful denial management solution

Payer Trends in Healthcare

- **Payers will continue to ramp up ways to cut costs**
 - Created policies, designed plans and narrowed provider networks to bring down healthcare costs
 - Unnecessary ED Visits or imaging services such as MRI or CAT scans w/o prior approval – shift to more cost effective outpatient setting
 - Narrowing provider networks bring down costs. Kaiser Family Foundation study found that nearly twice as many ACA Exchange and Medicare Advantage Enrollees were in narrow network plans as opposed to broad network plans.

Payer denial trends in healthcare

Greater emphasis on value-based care and contracting

- Payers and the CMS have pushed for more value-based care and payments,
- payers may move more into bundled payments, bonus payments and capitation as it pushes providers to care for the whole patient rather than receiving payments for individual services.
- payers will continue to leverage payment models that encourage patients to find care in the most cost-effective locations and use those service efficiently.
- Orthopedics, all post-acute services, oncology care, most elective surgeries, all episodes that patients control and a wide range of chronic conditions lend themselves to bundled payments that start at diagnosis,”

Payer denial trends in healthcare

More outpatient and virtual care utilization

- Payers have been pushing more patients to outpatient facilities as a way to cut costs.
- Care delivery is moving out of the acute care setting and into the community.

Virtual Care and Telehealth

- innovations will also play a larger role in keeping down costs. “Bundled payments hold great potential to become the driver of innovations that leverage the explosion of wearables, remote monitoring and greater patient engagement.

Payer trends in healthcare

Virtual Care and Telehealth

- Innovations will also play a larger role in keeping down costs. “Bundled payments hold great potential to become the driver of innovations that leverage the explosion of wearables, remote monitoring and greater patient engagement”.
- Reimbursement continues to be the main barrier to telehealth expansion
- Anticipated that virtual care will play a bigger role moving forward, including for initial consultations and follow-up visits that don’t require an onsite doctor visit.
- These trends will likely shift significant patient volume from higher-intensity settings to lower-intensity settings while maintaining or improving the quality of care and/or patient experience

Payer trends in healthcare

Consumers want cost, quality transparency

- Higher out-of-pocket costs and high-deductible health plans are the biggest reasons for this greater interest in transparency.
 - Increased cost-sharing payments
 - Increased deductibles and coinsurance

Health systems understand they need to provide pricing and outcomes information:

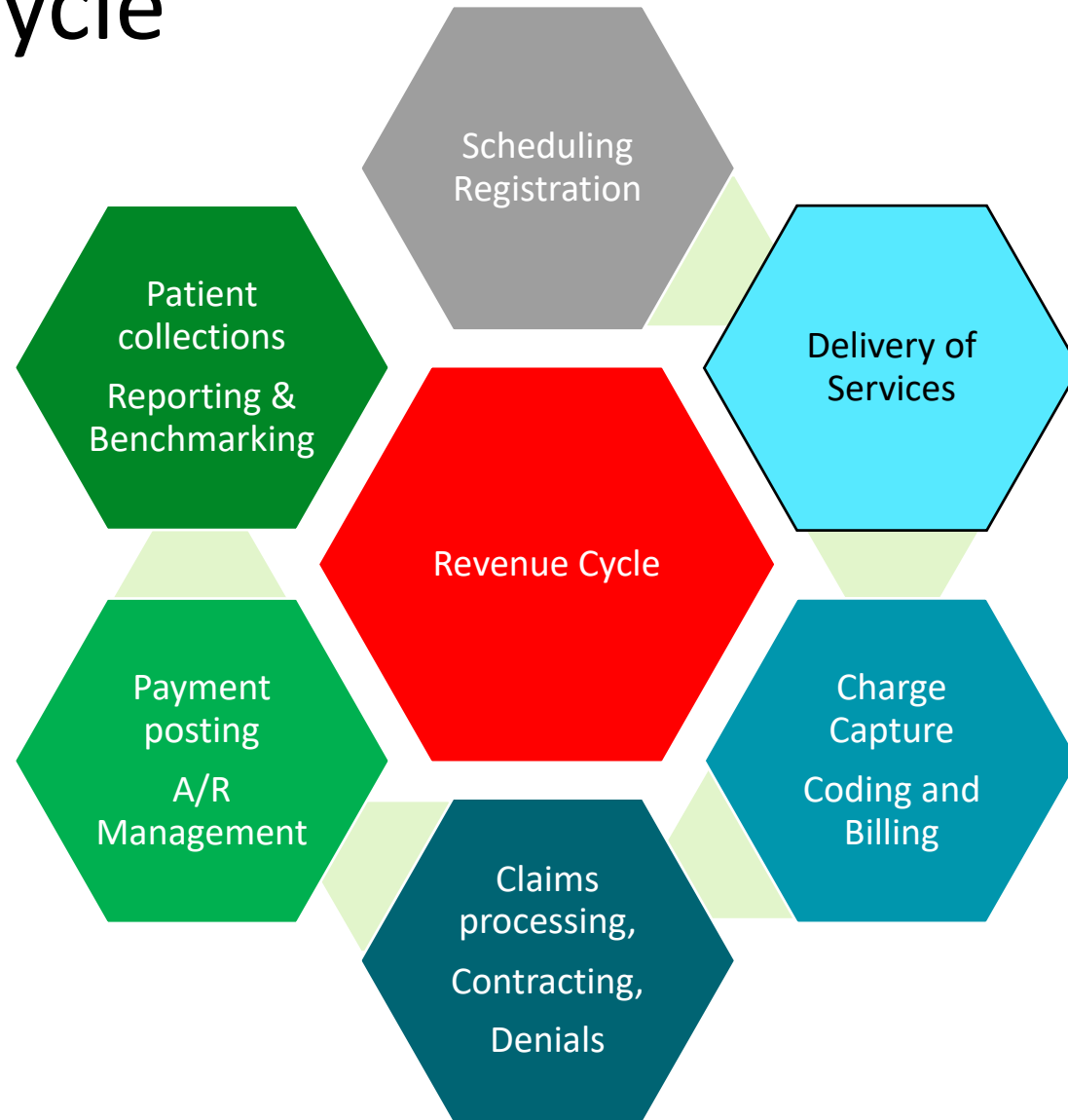
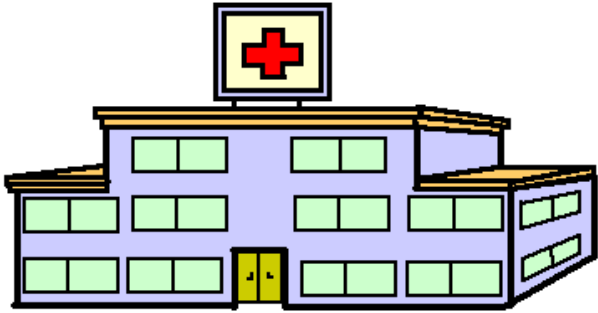
- created comparison shopping tools for consumers
- buyers will look for transparency, accountability for cost and quality across the continuum and consumer choice based on real competition,” Abrams said.

Payer trends in healthcare

.More payer/provider partnerships

- **Providers and payers have increasingly worked collaboratively,** partnerships like pay for performance, accountable care organizations, patient-centered medical homes and bundled payments.
- Increasingly, providers and payers are more concerned about managing patients' health rather than viewing them as volume.

The Revenue Cycle



What we know...there's a revenue management challenge.

Revenue Management challenges are affecting the bottom line.

- Hospitals are losing an estimated 3-5% of net revenue from inadequate revenue management; \$4.5 - \$9 million for an average 300 bed facility
- Gross charge denials have grown to 15% - 20% of the nominal value of all claims submitted
- Every rejection or denial introduces the risk of not getting paid.

3% - 5% potential lost revenue

15% - 20% claims denied

Increased denials = decreased revenue

The risk of denials

The national average for claim denials is 4%*.

Outpatient represent 15% of overall denials**.

The average outpatient denial claim is \$882 (automated denials) but as high as \$5,659 (complex denials).

The average cost for rework is \$25.00 per claim***.

Administrative costs to manage RAC appeals range from \$10,000 - \$50,000.

48% of denials are appealed with a 70% success rate.

Denied claims typically take 16 days longer to pay than claims that are not denied-affecting revenue cycles.

What
is
your risk?

*<http://revcycleintelligence.com/news/quantify-denial-rates-for-smooth-revenue-cycle-management>

**RACTRAC AHA RACTRac Survey, May 2014

***<http://www.healthfusion.com/blog/2014/practice-management/denial-management-can-afford-throw-away-25-denial/>

Loss of revenue

Denial – a refusal to pay as a result of the provider not adhering to insurance company policies/procedures, or pending receipt of additional information

Underpayment - incorrect payment resulting from pricing inaccuracies or differences in contract interpretation

Medicare Penalties

Lost revenue

- Undetected underpayments
- Incorrect payment due to incomplete or inaccurate billing
- Charges or codes are missing from the bill and are thus never considered for payment

Clinical Vs. Technical Denials

Clinical Denials

- medical necessity
- length of stay
- level of care determination
- coding, and other clinically driven factors
- clinical resources are required to address these denials

Technical denials

- issued when a claimant's application is rejected for non-medical reasons.
- traditional back-office resolution process prior to resubmission of a claim.

Hard Denials

Hard Denials (Appeal Required)

- Denied claim for elective service without pre-authorization
- Denied days, service or level of care for no concurrent authorization
- Denied as financially not responsible
- Denied as not a covered service
- Denied charge/procedure as bundled
- Denied for untimely submission

Soft Denials

Soft Denials (Additional information required)

- Denied ER claim pending receipt of medical records
- Denied claim due to missing /inaccurate information
- Denied claim due to charge/coding issues
- Denied charges pending receipt of itemized bill

The revenue cycle-where we lose the most

- Registration and Eligibility – 23.9% of claims
- Missing or invalid claims date – 14.6%
- Authorization & pre-certification of claims 12.4%
- Medical documentation requested – 10.8% of claims
- Service not covered – 10.1% of claims
- Medical coding and medical necessity problems 5.8% of claims
- Untimely filing – 3.5% of claims

Patient Access, Registration and Eligibility

Responsibilities

- Register patients
- Schedule procedures
- Check medical necessity
- Prior Authorizations

Barriers

- Typically entry level
- Fast paced
- Patients don't provide the correct information
- Lack of training and education
- Incorrect Plan ID
- No Verification of Eligibility/Benefits

Advance Beneficiary Notice of Non-Coverage

- Extends financial liability protections to Medicare beneficiaries
- Informs Medicare Beneficiaries in advance that a particular service will not be covered by Medicare
- The billing entity is always responsible and the ABN is to be provided before the item or service is provided
- Beneficiaries can then decide whether to have the service or treatment

Positive outcomes for proper ABN management

Providers and suppliers may charge their usual and customary fee for items or services that it furnishes to the beneficiary if:

- The supplier/provider furnishes a proper ABN
- The beneficiary agrees to pay, and
- Medicare denies the claim

Webinar results – OP and Professional CDI



Before submitting the claim

- Need to ensure that the service rendered is completely and accurately documented in the medical record
- the correct information is entered on the claim form
- that it is a covered benefit and eligible for payment
- Send it to the right address

Service Provider

- Physicians must register their NPI with the correct practice location and group assignment (particularly when physicians join a new group)
- Enrollment issues for nurse practitioners and physician assistants

Common reasons for denials

Duplicate claims

- hitting resubmit after not hearing back from insurance companies, which resets the clock on the time it takes to pay a claim. Denial is inevitable in this situation.
- Same date of service, same provider, missing date of service

Location

- The place of service must match the reported service/procedure code.
- Procedure done as an inpatient when typically done as an outpatient

Common reasons for denials

Lack of Medical Necessity

- Denials involving diagnoses produce issues of “medical necessity.”¹ Examine these denials carefully. Consider the service/procedure code when trying to formulate a response to the denial. The diagnosis code represents the reason for the service or procedure and might be a sign, symptom, or condition with which the patient presents. Medicare reimburses for procedures and services that are deemed “reasonable and necessary.”
- National Coverage Determinations (NCDs) to identify coverage requirements for frequent or problematic procedures or services
- Local Coverage Determinations (LCDs)
- Denials often involve a mismatched or missing diagnosis

Common reasons for denials

Problem with modifiers

- Some services are denied for being “incidental/integral” to another reimbursed service (i.e. bundled).
- Payors implement electronic payment edits that disallow separate payment for “related” services.
- The National Correct Coding Initiative (NCCI) identifies code pairs that should not be reported together on the same date by either a single physician or physicians of the same specialty within a provider group.

Common reasons for denials

Timeliness of submission

“Time limit expired”

- This is the most easily avoided claim denial.
- Most practices concentrate on larger claims first, which mean small money claims are put on the backburner.
- This causes a lot of small claims to be denied, which adds up to a lot of money.

Common reasons for denials

Claim lacks information.

- Human error
- person's date of birth
- spelling of a name
- These should definitely be examined and resubmitted. Otherwise they are just leaving money on the table.
 - When these claims are denied, it almost always doubles the time it takes to turn around a claim, affecting the practice as well as the patient.
 - front end scrubbers, such as technology that pre-screens claims, can help avoid this type of commonly-made mistake.

Common reasons for denials

Eligibility expired.

- When coverage is not verified beforehand to avoid issues
- patient's health insurance coverage has expired and the patient and practice were unaware.
- practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped.
- eligibility checks should be done again once the patient has arrived.

Claim not covered by insurer

procedures are not covered by an insurer

Problem can be avoided by using real-time verification.

Programs Related to Medicare Payment Reduction

Hospital Readmissions Reduction Program

This revolves around reducing readmission payments on common and costly conditions like heart attack or heart failure, coronary artery bypass graft surgery, pneumonia, chronic obstructive pulmonary disease (COPD), and hip/knee replacement.

The program aims to lessen these readmission cases by offering incentives to hospitals which provide quality care.

Programs Related to Medicare Payment Reduction

Hospital Value-Based Purchasing (VBP) Program

VBP implements Medicare payments based on performance using various measurements. Some of the factors considered include how they perform by comparison to other hospitals (over 3,000 hospitals across the country) and their performance improvement during a given period.

Hospital-Acquired Condition (HAC) Reduction Program

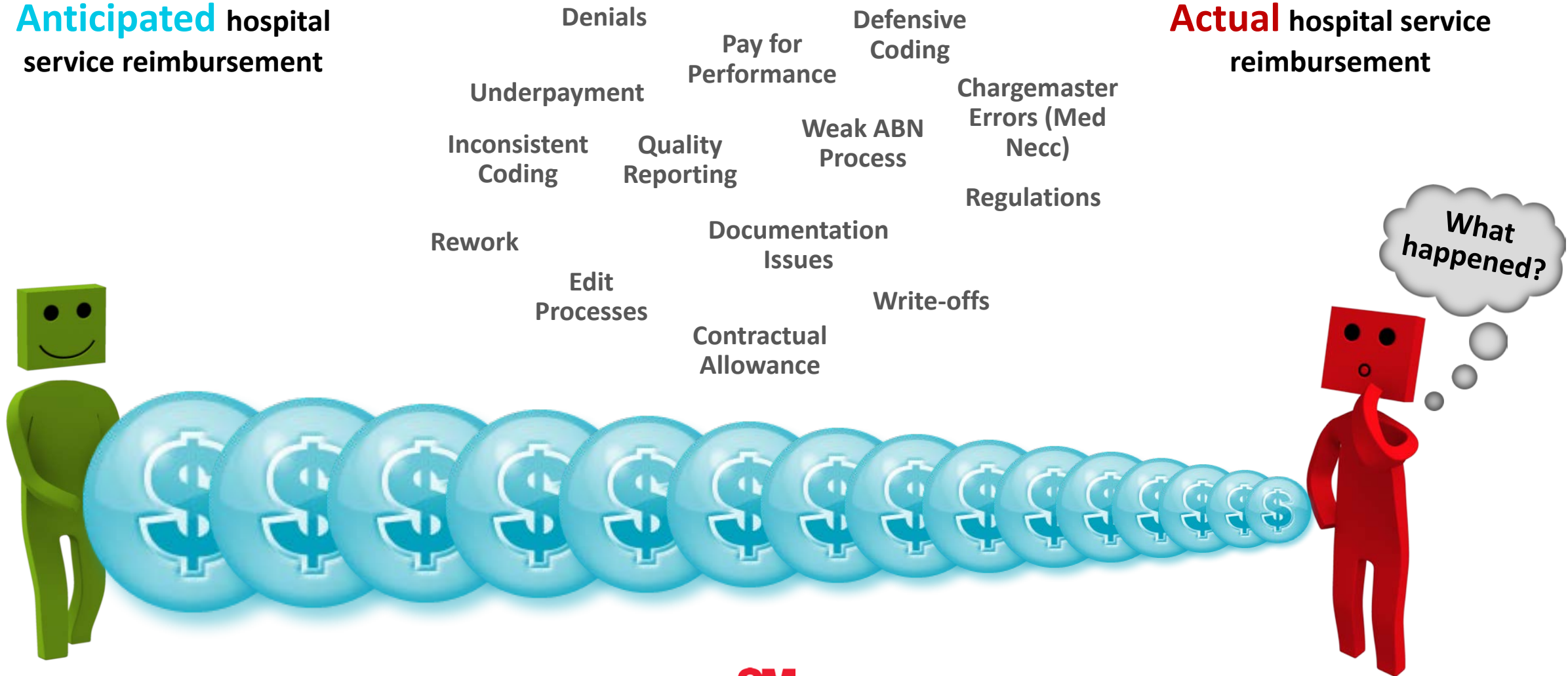
Medicare payments are reduced for medical facilities which are included among the lowest 25% bracket of poorly performing hospitals for certain standards, as imposed by HAC. Measurements revolve around patient safety improvement, not only the reduction of readmissions, like the programs above.

The outpatient revenue cycle

Problem: The struggle to keep dollars

Anticipated hospital
service reimbursement

Actual hospital service
reimbursement



OP Revenue Cycle Outcomes

Payment is denied

- Chargemaster errors
- Missing MN, CCI, Modifiers

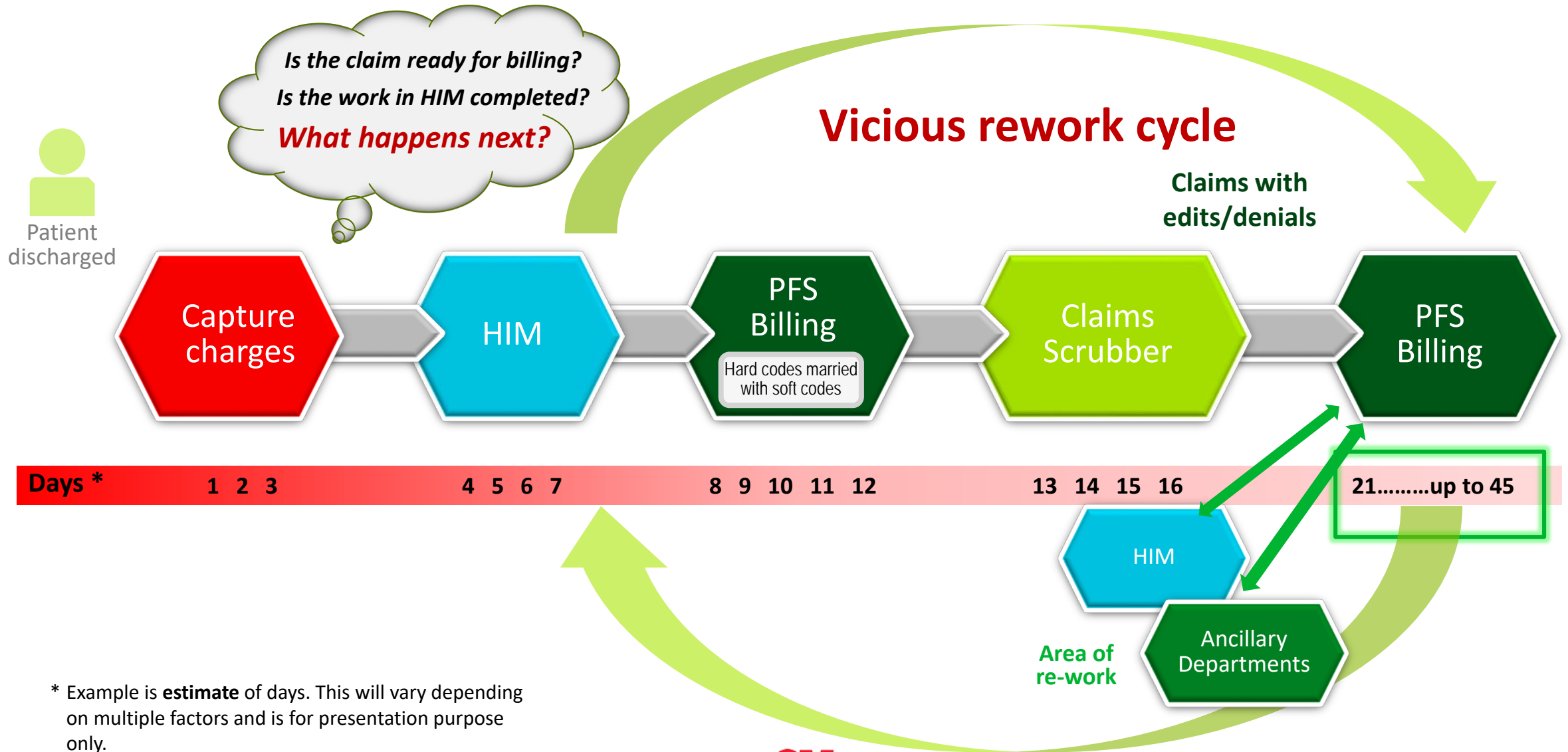
Partial payment

- Have to decide what to do here – accept the payment or resubmit
- Write off
- Compliance Issues

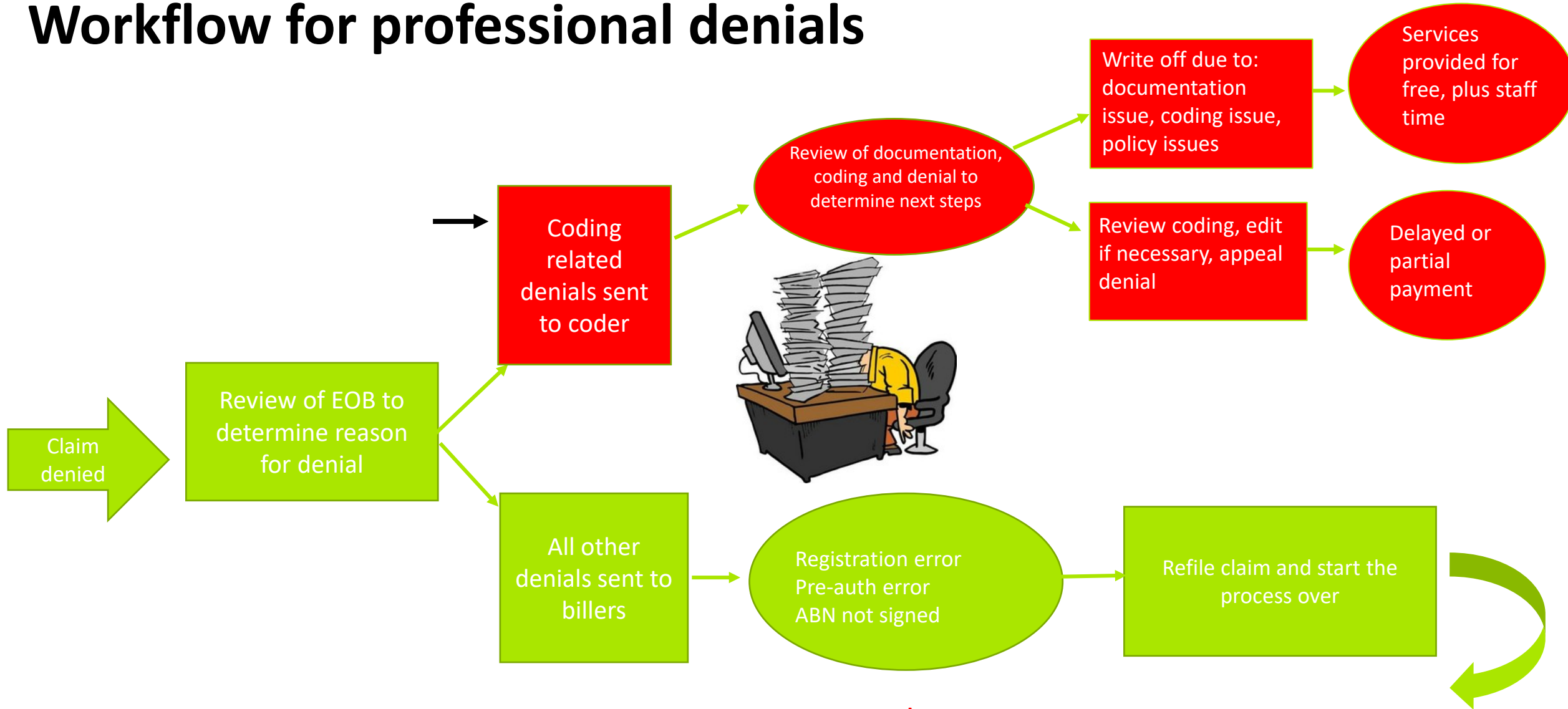
Under payment – Didn't charge enough

- Defensive coding
- Physician's picking their own E&M Codes and Caution
- Not enough Documentation

A typical Discharged Not Final Bill (DNFB) Timeline



Workflow for professional denials



On average, cost to rework a denial=\$25 each

Rework

APC Challenges: What's it costing you?

Payment delays, claim rejections, investment in rework and hidden write-offs common

Claim error rates of 8%-30% typical

Auditing

- Comparing documentation with codes from
 - Coders
 - Chargemaster
 - Remittance Advice

Cost of correcting rejected line items

- How many records have rejections?
- Cost of handling record a second time
 - \$50 - \$125 per record



Rework

What's it costing you?

“X” Hospital

Approx 120,000 outpt visits

(60% Medicare/Medicaid = 72,000)

- Assume a claim error rate: 8%
- 8% of 72,000 Medicare/Medicaid outpatient visits = 5,760
- 5,760 visits/claims x \$50 (avg. rework cost) =

\$288,000



Why does the current process fail?

- Poor/varying understanding (buy in) to coding rules
- Coding rules change every quarter
- Payment rules change throughout the year
- Different payers have different rules
- CMS shift from FFS (fee for service) to VBC (value based care) ICD coding is more impactful

Resulting In

System-wide provider burn-out

Uneven E&M coding, poor ICD coding, poor HCC capture, revenue loss

High cost to collect

Higher than necessary write-offs

Outsourcing to keep pace

Clinical Documentation Improvement Program

Gaps in:

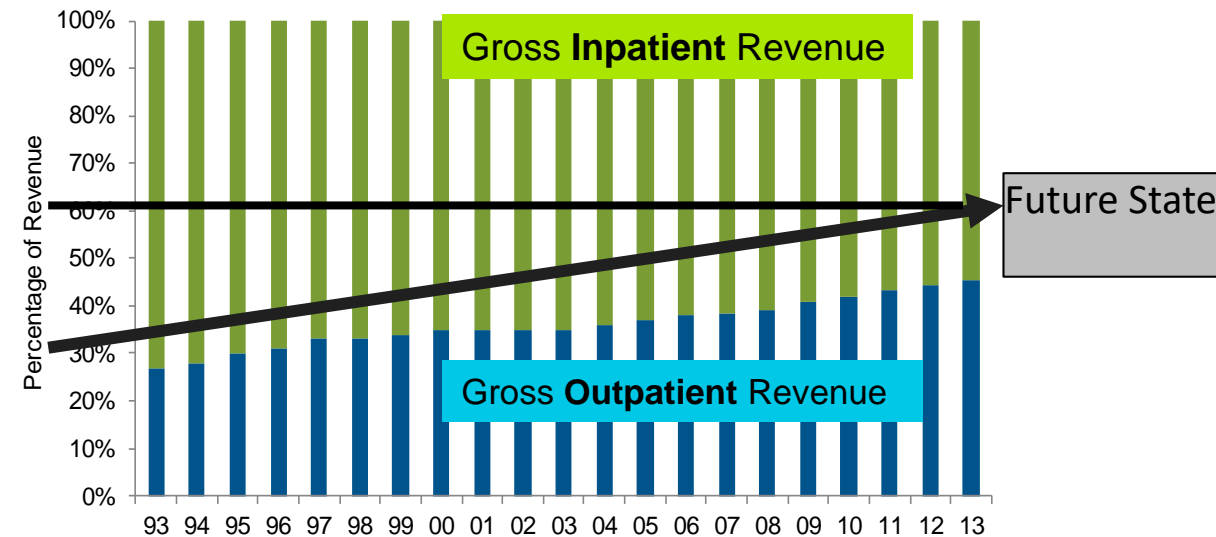
- Documentation
 - Coding
- Billing Processes
 - Compliance
- Medical Necessity
- Observation Status
- Revenue Recovery Risks

Bridging Gaps with:

- Objective claims analysis
- Implementation of technology
 - Best practice processes
- Regular performance monitoring

What Customers Have Told Us About Outpatient CDI

- A significant portion of existing revenue comes from outpatient services and is expected to increase by at least 25% over the next 3 years
- Only 5% have an existing OP CDI program
- 56% participants will invest in an OP CDI program in the next few years
- Most participants need help starting a program



Clinical Documentation Improvement Program - Outpatient

What is driving the trend to move services to the outpatient setting?

- Technological advances
- To lower the cost of healthcare

Questions related to outpatient claim scrubbing:

- What does it cost to get paid for outpatient services?
- What are the claim denial volumes?
- How much rework (number of claims) are being re-processing each day?
- How long does it take to be reimbursed from:
 - Original claim to payment or denial
 - Resubmitted claim to payment
- How much staff is involved in this process?
- How much time is invested in making sure charge information gets to the bill correctly?
- How often is information reprocessed because the root cause of the problem is not identified and corrected?

Clinical Documentation Improvement Program-Professional

Questions related to professional billing:

- How are the E/M levels and procedure codes assigned:
 - Coder?
 - Providers?
 - Superbill?
- Is the provider documentation routinely reviewed to support coding?
- Are E/M levels graphed for trend provider utilization?
- What impact do they believe HCCs will have on their reimbursement, if any?

Reasons an organization needs OP or PS CDI

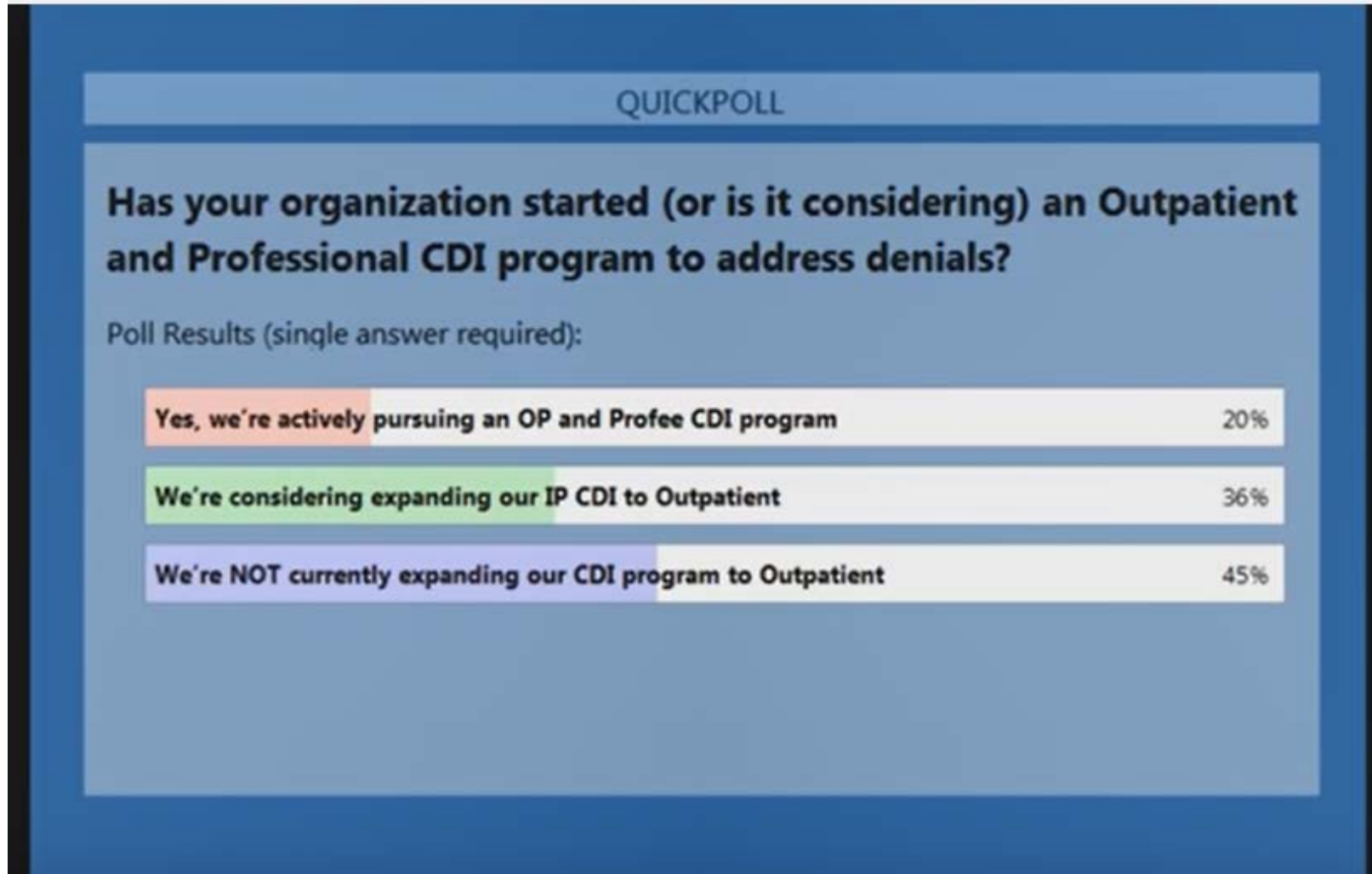
Reasons

- Missed medical necessity
- Documentation may not represent the patient care delivered
- Physician documentation may lead to undercoding or overcoding
- Issues documenting in the EHR
- Need more documented on surgical procedures
- Charge entry clerks are coding

Challenges

- Other priorities
- No resources
- Disparate departments involved
- No metrics to measure the need
- Cost benefit and return on investment

Webinar results – OP and Professional CDI



A model approach to managing denials

- Leverage and expand your existing CDI programs into outpatient and professional services
- Perform an assessment. The assessment will identify process gaps, policy change requirements, redundant practice and overall workflow management along with recommendations.
- Integrate the results of the assessment with key stakeholders to integrate new policies, processes, education and technology/tools.
- Continually validate that the processes are making an impact.

Benefits of documentation review program.



Documentation is the key to all revenue; must be timely, comprehensive and accurate.



Incomplete documentation or non-compliant criteria can trigger audits, overpayments, and / or underpayments.



Revenue (penalties) and cash-flow is based on the supporting documentation.



Identifies point of process and workflow to ensure documentation accurately reflects new initiatives, such as HCCs and quality indicators.

Assessment... what we find

- Decentralized faculty medical groups
- Inconsistent coding and billing practices
- Documentation not regularly reviewed
 - physicians picking their own codes
- Indiscriminate use of modifiers
- Labor intensive denial management
- Lengthy delays in revenue capture
- Medical necessity, CCI and other edit write-offs
- Inefficient and delayed claim submission
- Labor intensive back scrubber

Examples of Findings



Incomplete documentation

Medical Necessity in the Emergency Room - \$80,000; outside emergency room - \$200,000

Impact:
Lost revenue; inaccurate documentation

Process and workflow

Heavy scrubbing on the back-end of the revenue cycle process.

Impact:
Revenue hold due to rework

Reimbursement not provided for care delivered

Inpatient procedure written as "outpatient" - \$123,000

Impact:
Lost revenue

Compliance and accuracy

Lack of cooperation for complete physician documentation creates documentation compliance challenges.

Impact:
Increased risk of audits or denials

Examples * of identified issues

* Examples represent sample of documentation review findings

Examples of Findings



Examples* of identified issues

Incomplete documentation	Cash flow and claim delays and / or holds	Reimbursement not provided for care delivered	Compliance and accuracy
3% of x-ray services did not have sufficient documentation to support both the technical and professional components.	Maintaining paper records for some services. Documentation should be readily accessible in one central medical record.	Services documented in the record but not coded and billed.	Reporting levels of E/M were not supported by documentation. Potential overpayments identified for resolution.
Impact: Lost revenue or potential denials	Impact: Delay with processing	Impact: Lost revenue; inaccurate documentation	Impact: Risk of audits or denials

* Examples represent sample of documentation review findings

Findings from Previous Engagements

Outpatient

- Inpatient-only procedures not identified in time to get the order prior to surgery
- Medical Necessity edits remaining after scrubbing (both ED and non-ED)
- Significant scrubbing performed to get the claims out the door
- Emergency Department E/M level skewed to highest level on 50% of visits

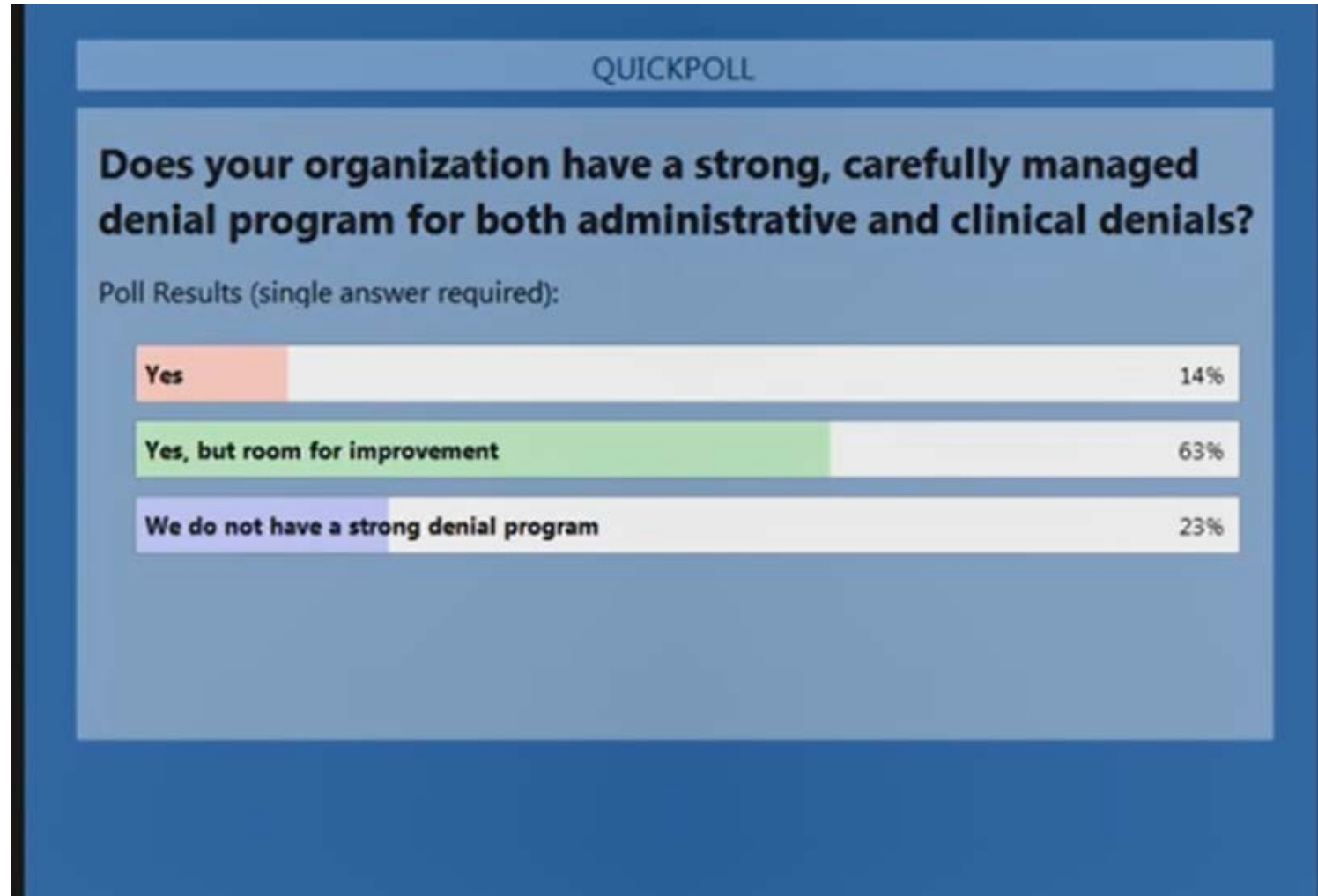
Provider

- Based on documentation, E/M levels are coded either too high or too low
- Critical care charged when patient stable or improving
- Missing charges for procedures and screening services rendered during visit
- Missing supporting documentation for surgical procedures
- Inappropriate modifier placement

Assessment... what we find – Best Practices

- Centralized scheduling, registration, coding and billing
- Coder/CAC review of documentation
- Coders have access to all charges and edits at time of coding
- ABN process, physician involvement, bill services performed, modifier application of GA, GZ, GY
- Fewer denials due to pre-bill scrubbing
- Timely submission of clean claims
- Root cause edit identification, reduction, and/or elimination
- Compliant application of modifiers
- Fewer denials due to pre-bill scrubbing
- Timely submission of clean claims
- Strong ABN Process
- Surfacing potential issues of medical necessity, etc. and access to edits at the time of coding

Webinar Results – Denial Management Program



Building your Denials Management Program

- Customize the program to your institution and workflow
- Quantify, categorize and prioritize denials
- Create a denials team– is everyone involved, should they be?
- Review your patient access, registration and eligibility process
- Perform an assessment of your current state
- Leverage and advance your CDI program to the outpatient setting
- Use claims management software and technology proactively to prevent denials
- Monitor and validate any process change

Best Practices – Software Solutions

- Eligibility systems
- Case management systems
- Order entry systems
- Claims Management Systems (Comprehensive scrubber/Editors)
- Charge capture systems
- Contract management systems
- Patient Accounting/host systems
- Denial management systems

Drawbacks

- Implementation cost
- Resources to integrate

Best Practices - Multidisciplinary Team

Multi-disciplinary team

- All revenue cycle stakeholders involved
- Regularly scheduled meetings
- Reporting on agreed-upon KPI

Training and Education

- Cross train coders and billers
- In-service & external training
- IT training
- Reference Materials and Resources

Best Practices – Information Sharing

Information sharing

- Contracts accessible electronically
- Shared underpayment /denial trend reporting
- Shared network resources / reference materials
- Share issues with payers

Managing the claims denials process

- Revamp your claims denials process
- Understand why the claims were denied in the first place (educate patients)
- Keep your denial management process organized
- Complete claims denials in a week
- Track your progress and success
- Identify most common denials and trends
- Outsource your denial management program

Understand why these claims were denied in the first place

Knowing why your patient's claim was denied is important if you want to streamline your process to:

- a.) Maximize your collections revenue
- b.) Prevent future claims from happening

Remember, not all of your patients are knowledgeable in regards to the insurance denial system, so you need to do your job to educate them on how they can solve the issue. Thanks to Hospital Consumer Assessment of Healthcare Providers and Systems Hospital Surveys, patient satisfaction is more important than ever, so being able to help your patients in a timely and effective manner is vital to the overall success of your organization.

Keep your denial management process organized

Losing track of denied claims is like losing cash from your back pocket. Once or twice, it's frustrating. But as it keeps happening, you'll have a serious problem on your hands, as those denied claims have a way of piling up over time. If you don't have an organized system in place to keep track of your denials, you won't even know when they're missing in the first place.

Many hospitals are adopting tools and technologies to help them see when and why their claims are being lost amongst the shuffle. This helps hospitals manage their denials and keep an eye on which ones still need attention. And keeping your denials moving at a brisk pace is the best way to maximize your denial collections revenue.

Complete claim denials within a week

Creating a strong workflow for your denied claims is paramount to establishing a successful denial strategy. When you receive a denial from an insurance company, you should have a process in place to ensure that denial will be corrected within a week.

To do that, you need to establish a workflow that can track your claims as they enter and leave your system. It's important because, not only will it lead to a more effective system, but many insurance companies set limits on how long a hospital has to appeal a denial. And losing money you're owed because you're a day past the "time limit" isn't a conversation any party wants to have—except maybe the insurer.

Track your progress and success

Keeping track of your process is important, as it helps organizations see which areas are working, and which need further support. That's why you should be documenting both your wins and losses, in regards to your unpaid claims. The ultimate goal is improving the efficiency of your organization, and sticking close to the analytics is a great way to prove the value behind your strategy.

- Are claims being denied for the same reasons?
- Are denials being taking too long to complete?
- Are denied claims getting lost or expiring?

Identify the most common denials and trends

Identifying the types of denials that are most common to your organization is also a crucial component of establishing an effective denial management process. Each health organization is different, but in general, the top causes for denials are:

- Coordination of Benefits, PIP (personal injury protection-no fault) Applications, Accident Details, Pre-existing Conditions, Name Misspellings

Each of these denials may seem like a small problem initially, but as you continue to track and analyze these trends, you may reveal larger issues in your organization. Do some due diligence, and create a checks and balances system in your denial management strategy to ensure you're not just thinking what's trending now, but also what will be trending five years from now. Plan ahead, and you may see your list of common denials start to shrink.

Outsource your denial management process

Outsource an expert healthcare business process outsourcing company that specializes in revenue cycle services, including expertise in denial management. When choosing which outsourced solution to use, there are two questions you should ask:

1. Will it bring in more money from patients and payers?
2. Will they give exceptional customer service to ensure and exceed patient satisfaction?

The top denial management providers use specialized teams that are highly trained in working with, negotiating and navigating the complexities of the insurance system. By outsourcing your denial management services, you'll have more time to focus on other areas of the hospital that require your attention.

Questions



Thank you

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