Retrospective Denials Management

Weaving together the Clinical, Technical, and Legal Components

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Our goals for our time today

• An overview of effective Denials Management approach
• Key Performance Indicators – MAP Keys
• Description of team composition
• Review of possible Denials Management processes and workflows
• The importance of accurate data collection and analysis
• Specific Denials Management challenges
How Reform is Affecting the Revenue Cycle

- The complexities of today’s coverage and reimbursement landscape demands a level of focus and expertise unparalleled in the past.

<table>
<thead>
<tr>
<th>Revenue Cycle Imperatives</th>
<th>Expanded Coverage</th>
<th>Payment Cuts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improve Performance and Efficiency</td>
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<tr>
<td>Patient Access - Eligibility Processes</td>
<td>Denials Management/ Denials Prevention</td>
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</table>

* Illustration adapted from hfmap Revenue Cycle Excellence presentation on Reform impacts
Define a Denial

- What is a denial?
- How do you calculate a denial?

- ANY CLAIM PAID LESS THAN EXPECTED
Some of the keys to success include:

- Systems that collect data, and processes that translate that data into information
- Front end processes to ensure eligibility, notification, and authorization
- Ongoing and timely clinical review and communication with payors
- Contract management & IT systems that accurately calculate expected payments using complex reimbursement formulas.
- Integrated denials management for both technical and clinical
Overview of Denials Management Process

• Role of the Denials Management Team
  – Take responsibility for an assigned portion of a hospital’s accounts receivable, beginning with the identification of a clinical, technical, or legal denial.

• The process should include:

  - Initial Review
  - Clinical Review
  - Clinical & Technical Appeals
  - Preparation & Referral to Legal
  - Joint Operating Committees with Payors
  - Follow up
Seamless integration of business office and clinical audit operations is imperative

- A process must be in place between “AR staff” and “clinical staff” – The Hand-off
  - Delivery of clinical denials to clinical staff (paper vs. electronic)
    - Nurse Audit request (explanation of problem)
    - RAs/EOBs/UBs
    - Medical records
  - Clinical audit inventory must be managed
    - Distribution to clinical staff - Prioritization methodologies
    - Productivity measurements
    - Clinical outcome reports
Denials Management Team Composition

• Diverse team of experts comprised of:
  – Project Management
  – Nurses & Medical Directors
  – Accounts Receivable/Billing Specialists
  – Inpatient/Outpatient Coders
  – Clerical Support Specialists
  – Legal Support

• Considerations when building the team
  – Existing resources, reporting relationships
  – Corporate Partners
Example of Denials Management Work Flow Model


- Nurse Audit (Accept)
- Appeal Prepared & Sent (Appeal)
- Follow Up (Accept)
- Adjust – Close (Accept)

Referral
Denials Management Data

• The data that is generated from the Denials management process is almost as valuable as the additional revenue.

• This information can be used by the facility to focus concurrent CM and UR efforts as well as improve clinical and PFS functions.
HFMA’s MAP Keys

• Sets a national standard for revenue cycle excellence

• Define the critical indicators of revenue cycle performance in clear, unbiased terms

• Ensure consistent reporting

• Each Key has a Purpose, Value and Calculation
Initial Denial Rate – Zero Pay

• **Purpose:** Trending indicator of percentage claims not paid

• **Value:** Indicates providers’ ability to comply with payer requirements and payer’s ability to accurately pay the claim

• **Calculation**

  Number of zero paid claims denied
  Number of total claims remitted
Initial Denial Rate – Partial Pay

- **Purpose:** Trending indicator of percentage claims partially paid

- **Value:** Indicates providers’ ability to comply with payer requirements and payer’s ability to accurately pay the claim

- **Calculation**
  
  Number of partially paid claims denied
  
  Number of total claims remitted
Denials Overturned by Appeal

• Purpose: Trending indicator of hospital’s success in managing the appeal process

• Value: Indicates opportunities for payer and provider process improvement and improves cash flow

• Calculation

  Number of appealed claims paid

  Total number of claims appealed and finalized or closed
Denial Write-Offs as a Percent of Net Revenue

• Purpose: Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount

• Value: Indicates provider’s ability to comply with payer requirement and payers ability to accurately pay the claim

• Calculation

  Net dollars written off as denials
  Net patient services revenue
Conducting a cause and effect analysis can help to identify the root cause(s) for denials and identify opportunities for improvement and education that will ultimately prevent future denials for the same reason.

Ideally, data from denials should directly feed continuous improvement efforts.
Illustration of Cause and Effect Analysis

Outcomes
Analysis of the Denials Management data as well as root causes often reveal issues in multiple areas...

**Denials Hospital Issues**
- **Technical**
  - Prior Auth
  - Billing error
  - Wrong Insurance
  - Contract Coverage
  - Eligibility
- **Clinical/Medical**
  - Payment less than expected
  - Non-covered services
  - Concurrent denials
- **Legal**
  - Grievance/appeal process
  - Multi-hospital suites

**Denials Health Plan Issues**
- **Technical**
  - Prior Auth
- **Clinical/Medical**
  - Onsite review
  - Medical Director
  - LOS/Delay days
  - Not medically necessary
  - Non covered service
Sample Denials Management Analysis

• System wide, the Areas *not under the Hospital System’s immediate influence* (Physician, Health Plan, and Patient) represented nearly 73% of the resolved denied claims which was $6.5M of the total $8.6M.

• Front End and Back End combined represented just under 10% of the total number of resolved denied claims, and just under 9% of the dollars.

• We had the most success appealing claims from the Health Plan Denial Area at 67% of total recovered dollars. *The Physician Denial Area was a significant challenge with only 7% of total recovered dollars* on all resolved claims.

• The Physician Denial Area had the largest number of resolved denied claims at each hospital.
• At one hospital system an in-depth review demonstrated that the hospital had specific clinical issues...
  – Physician delay in discharge,
    • Patients no longer meeting inpatient criteria and documentation insufficient to support continued stay.
    • In cases where the patient is waiting for skilled nursing facility placement, roughly 40% of denied dollars were recovered on appeal/reconsideration.
  – Overutilization of ICU
    • Short pays by health plans where the ICU level is not supported by documentation.
    • On appeal 32% of denied dollars in this category related to Physician use of ICU were recovered.
### Sample Denials Management Data

<table>
<thead>
<tr>
<th>Client</th>
<th>Product</th>
<th>Denial Reason</th>
<th>Number Of Accounts</th>
<th>Dollar Amount Denied</th>
<th># of accounts disputed</th>
<th>Percentage Of Accounts Appealed</th>
<th>Dollar Amount Appealed</th>
<th>Percentage Of Dollars Appealed</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>AHCCCS/Health Plan Issue</td>
<td>7</td>
<td>$1,445.34</td>
<td>5</td>
<td>71%</td>
<td>$864.86</td>
<td>60%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Delay days or Delay in care</td>
<td>0</td>
<td>$-</td>
<td>0</td>
<td>0%</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Denied days meet SNF(sub-acute) level of care</td>
<td>0</td>
<td>$-</td>
<td>0</td>
<td>0%</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Disallowed charges</td>
<td>2</td>
<td>$36,992.08</td>
<td>2</td>
<td>100%</td>
<td>$36,988.52</td>
<td>100%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Documentation does not support expected tier</td>
<td>12</td>
<td>$7,382.96</td>
<td>11</td>
<td>92%</td>
<td>$7,117.08</td>
<td>96%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>ESP or Dialysis days only</td>
<td>1</td>
<td>$127.32</td>
<td>0</td>
<td>0%</td>
<td>$-</td>
<td>0%</td>
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<tr>
<td>ABC</td>
<td>ZB</td>
<td>FES/Emergent criteria or Stabilization</td>
<td>49</td>
<td>$17,914.57</td>
<td>26</td>
<td>53%</td>
<td>$13,144.57</td>
<td>73%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Mental health plan responsible for denied days</td>
<td>1</td>
<td>$72.06</td>
<td>1</td>
<td>100%</td>
<td>$72.06</td>
<td>100%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>OBS. V. Inpatient</td>
<td>1</td>
<td>$1,078.82</td>
<td>0</td>
<td>0%</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>ABC</td>
<td>ZB</td>
<td>Other</td>
<td>2</td>
<td>$3,452.14</td>
<td>1</td>
<td>50%</td>
<td>$3,206.40</td>
<td>93%</td>
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<tr>
<td>ABC</td>
<td>ZB</td>
<td>Technical Issue</td>
<td>22</td>
<td>$7,846.50</td>
<td>22</td>
<td>100%</td>
<td>$7,846.50</td>
<td>100%</td>
</tr>
<tr>
<td><strong>TOTAL ZERO BALANCE</strong></td>
<td></td>
<td></td>
<td><strong>97</strong></td>
<td><strong>$76,311.79</strong></td>
<td><strong>68</strong></td>
<td><strong>70%</strong></td>
<td><strong>$69,239.99</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>
Tracking of short pays over time will identify unwanted trends, not always reasons.
Sample Denials Management Results

- **All Financial Classes combined:**
  - $26,170,509.47 in denied charges with a recovery rate of **54.05%**

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>Denied Charges</th>
<th>Recovery Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$13,172,392.33</td>
<td>42.60%</td>
</tr>
<tr>
<td>Commercial</td>
<td>$5,094,094.71</td>
<td>72.03%</td>
</tr>
<tr>
<td>Medicare-Risk</td>
<td>$2,069,817.68</td>
<td>53.35%</td>
</tr>
<tr>
<td>BCBS</td>
<td>$4,116,301.23</td>
<td>79.20%</td>
</tr>
<tr>
<td>Medicare</td>
<td>$1,711,123.65</td>
<td>29.24%</td>
</tr>
</tbody>
</table>
By using the data to focus concurrent processes and drive educational efforts the Denials Management Team and the hospital were able to produce the following results:

- After a concentrated education and document improvement effort the overall recoveries from the Physician Denial area showed a dramatic increase (40%).

- The fact that the recovery rate increased while the denial rate remained stagnant is an indication that the documentation improved, but the plan’s behavior is lagging behind.
Specific Denials Management challenges

• Emergency Department denials
  – Observation versus Inpatient
  – Inpatient cases where documentation does not support Inpatient level of care
    • Many times are being paid $0.00
    • Very difficult to appeal retrospectively with a valid inpatient order
  – Best place to catch these denials is at the time of admit
    • Denials Management data can be used to focus these efforts
Specific Denials Management challenges (cont.)

• **Elective Surgery denials**
  - Scheduled and authorized as outpatient, but made inpatient after the procedure
  - The chart contains an outpatient authorization, an inpatient order, and the documentation supports outpatient level of care.
    • These claims are either being short paid or paid at $0.00
  - Very difficult to argue on appeal with out excellent documentation of complications
  - Addressing these denials concurrently will require excellent communication with the Clinicians, Scheduling, and Case Management
    • Documentation improvement program is also a possibility
Specific Denials Management challenges (cont.)

• Discharge to a lower level of care
  – Awaiting bed availability or placement
  – Possibility of partnering with appropriate alternative care facilities
    • Risk-sharing

• Readmission Denials
  – The same or similar diagnosis
  – Can be Technical and/or Clinical issue
Clinical Denials Management is an essential component of the revenue cycle.

- Prevents money from being left on the table.
- Provides great insight into process improvement opportunities.
- Requires specific, detailed processes and resource allocation.
- Systems for data analysis and comparison are crucial.
- Strong clinical integration is imperative.
Thank you for your time!

Questions?
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