A Common Sense Approach to Denial Management

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Topics

- “The Basics” Denial Management
- What we’ve learned in the past 10+ years…
- Denial Analytics “Then” and “Now”

The Basics – Denial Management

- ✓ Sponsorship from Hospital Administration (CFO Buy-in)
- ✓ Denial Prevention Team Approach (Monthly Meetings)
- ✓ Enforce Departmental Accountability ((Honest effort by all)
- ✓ Claim/Line Level Denial Intelligence, and Automated Work Queues for Follow Up Staff (most providers have a tool)
- ✓ Efficient Denial Report Delivery Process (Departments/Physicians)
- ✓ Set Goals and expectations (Depends on the organization)
- ✓ Education and Collaboration! (Root Cause, Department notification, follow thru to the best of their ability)

Goals and Objectives – Denials

- Accelerating delayed reimbursement
- Reduce lost revenue
- Optimize upstream performance
- Bolster organization wide fiscal accountability

What drives Denial Management?

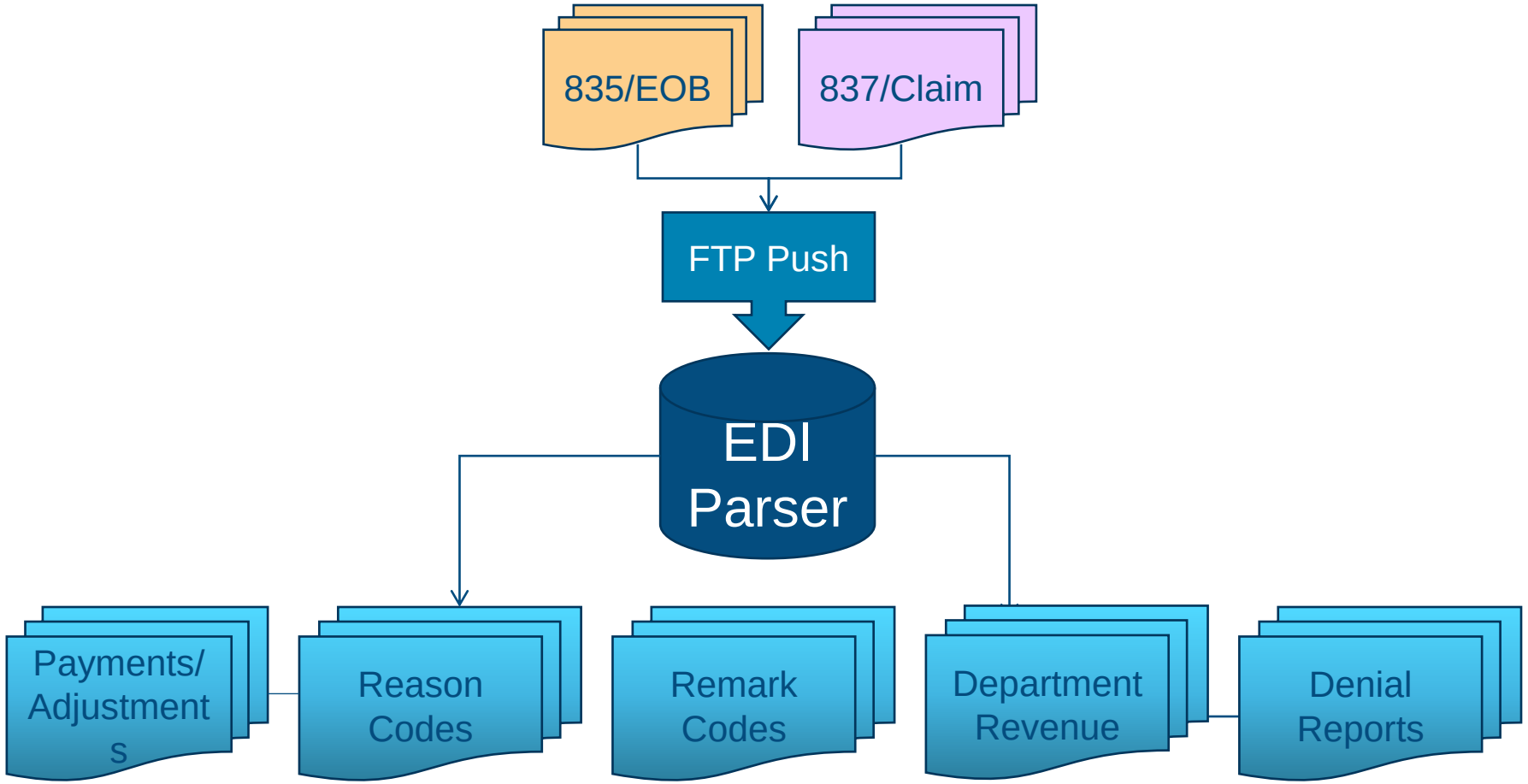
- ✓ ANSI 835 Remittance/Payment Files (Std EDI File)
- ✓ System/Technology/Tools (EDI Parser)
- ✓ People/Staff/Analyst/Billers*

System, Technology, Tools

- ✓ Parses, segments and indexes the 835 data
- ✓ Reporting (Trending, Prioritization)
- ✓ Distribution (Work-flow)

Simply Organizes the Data

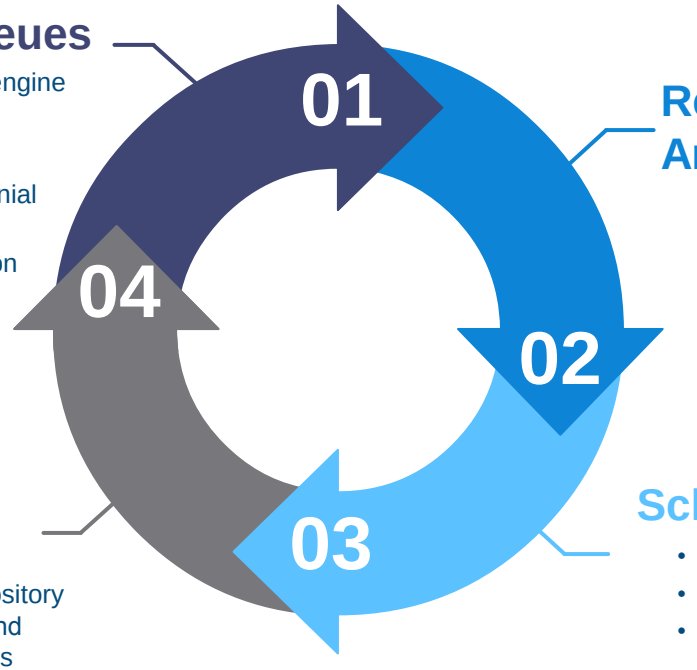
EDI Parser


835/EOB
837/Claim
FTP Push
EDI Parser
Payments/ Adjustments
Reason Codes
Remark Codes
Department Revenue
Denial Reports

Automation, Distribution, and Segmented Analytics

Denial Work Queues

- Customizable rules engine
- Productivity tracking
- Auto Prioritization
- Auto and Manual Denial Assignments
- Auto Letter generation



Reimbursement / Denial Analytics

- Summary Level Dashboards
- Reporting Options
- Data extracts
- Denial Categorization

Document Archiving

- Remittance repository
- EOB's on demand
- Denial Templates
- Root Cause and Solution Documentation

Scheduled Reporting

- Automated FTP downloads
- Work-list distribution
- Senior Leadership Summary Reports, i.e. Month End Reporting

Analyst/Biller/Coder/Registrar

- ✓ Dedicated Resource(s)
- ✓ Diverse expertise
- ✓ Leadership Qualities

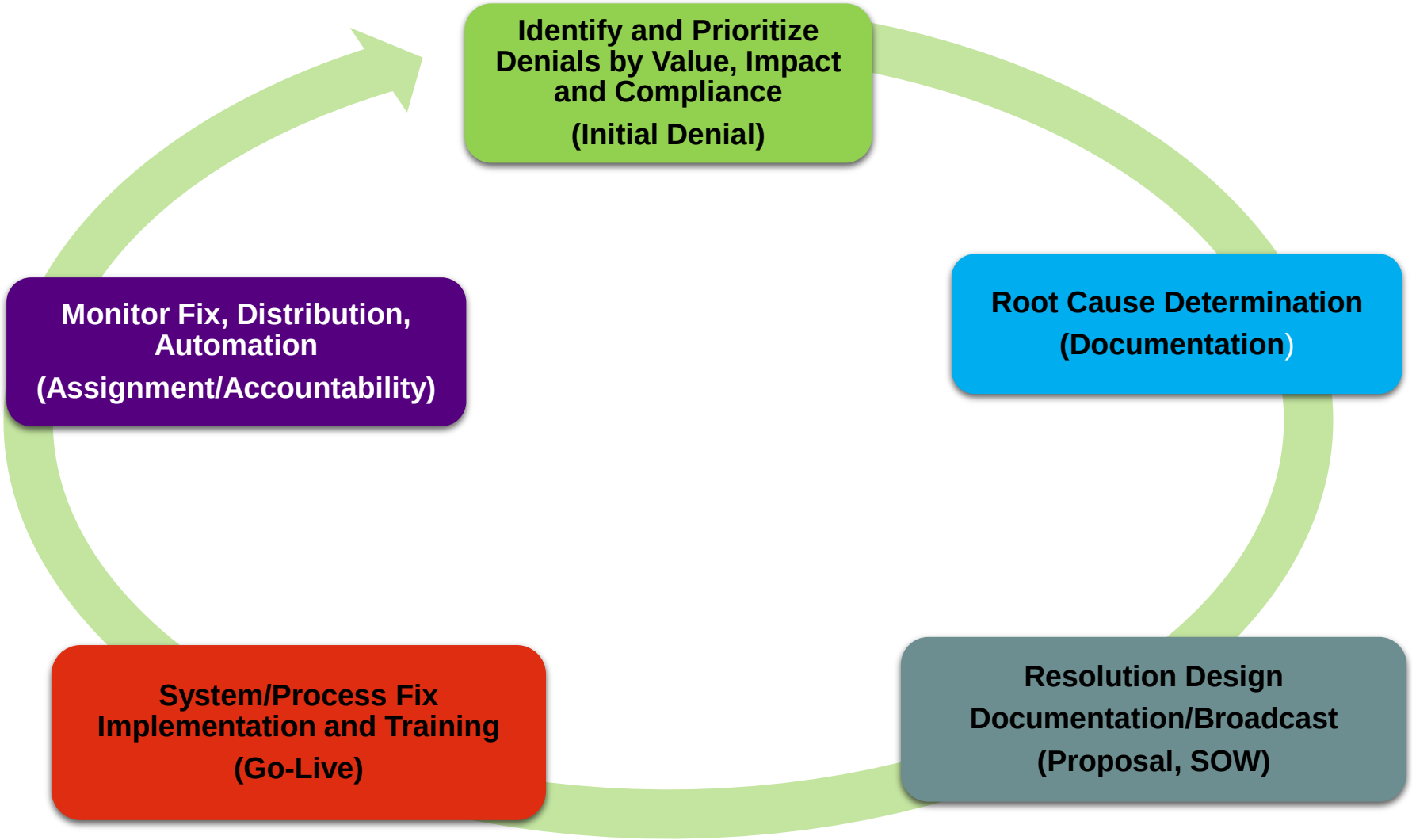
Generating “Value” from Denials Must be a (2) two-pronged approach

Prong 1 (Analyst)	Prong 2 (Biller, Coder, Reg.)
Non Work-flow	Daily Work-Q’s
Requires a diverse skill set	Repetition, Fixing of known issues
Likely involves multi-departments, staff and systems	Works mostly alone, independent of other staff and/or departments
Root Cause Determination	Very good at getting claims paid
Solution design and Implementation	“Real-time” Denial Remediation
Staff training and support	

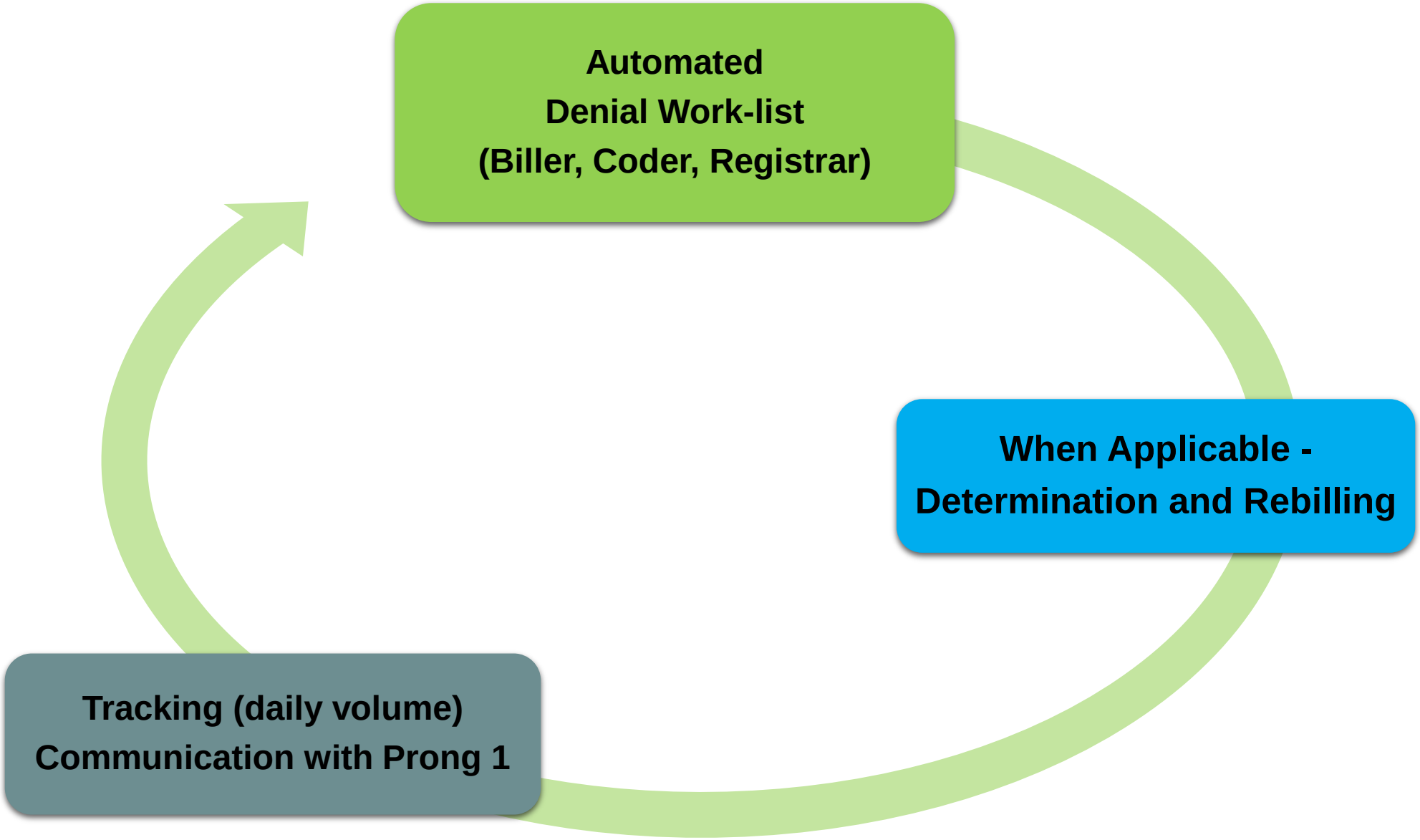
Frequent meetings between the two Prongs is imperative to accelerating “Value” associated with Denials. The most successful Denial Management Initiatives are supported by a Denial Team, frequent meetings, up-to-date denial data and denial process documentation.

Working denied claims, without addressing the root cause, will impede efficiency throughout your revenue cycle.

Prong 1: Denial Work-flow (Analyst)



Prong 2: Denial Work-flow (Biller, Coder, Registrar)



Keys to Mastering the Basics

1. Understand there's no "Magic Button" for Denials.
2. Dedicated Denial Analyst(s) and/or Denial Team
3. Someone needs to lead Denial Management
4. Documentation, Templates, Findings, Action Items, Assignments
5. Department and Physician Accountability (open minded participation on both sides)
6. Consistent commitment (knowing it takes a solid 3-6 months to get organized).
7. Stay positive, be positive in communications and build report with departmental leaders.
8. Leaders of your Denial Management Initiative must "Earn Trust"!

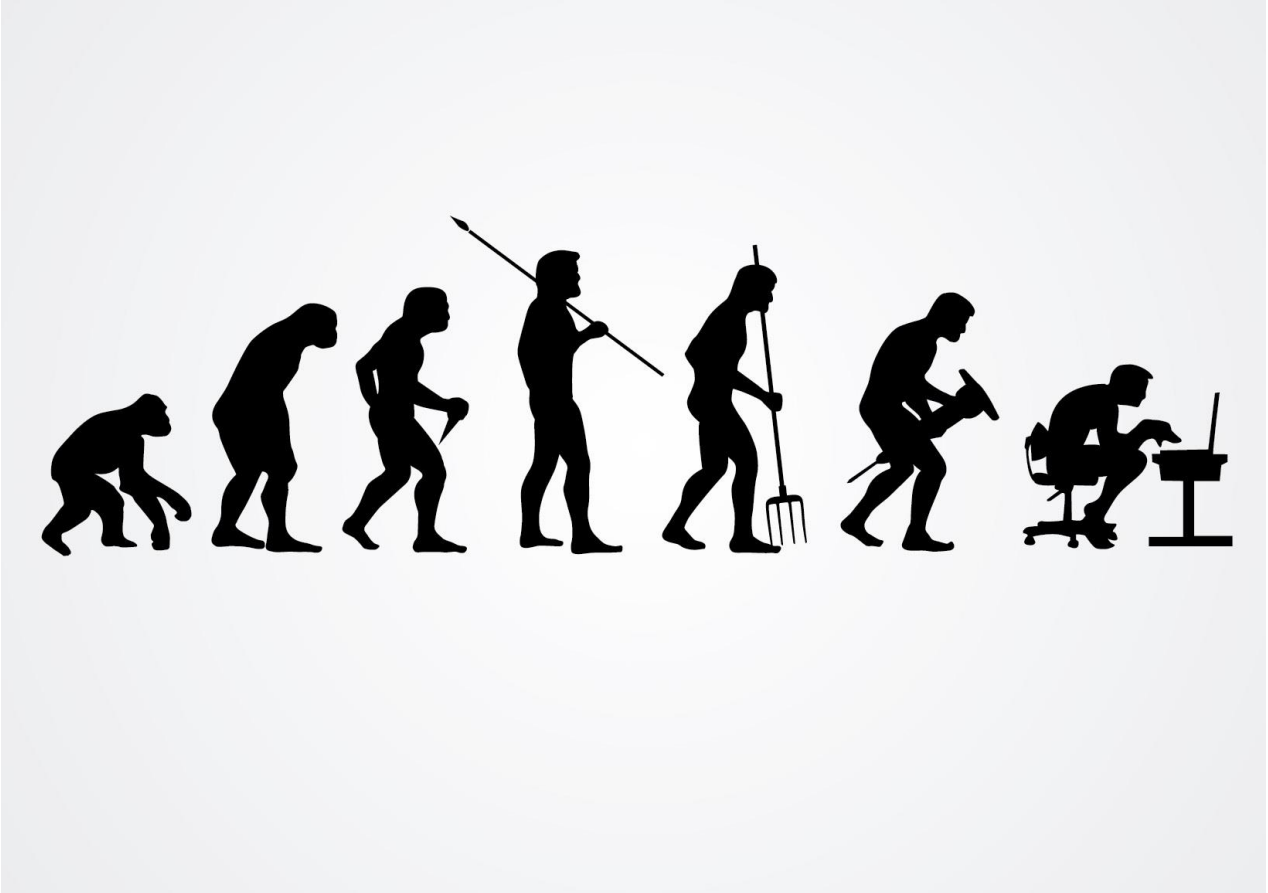
What have we learned in the past 10 years?

- ✓ Denials are frustrating!
- ✓ It is difficult to stay organized and feel confident in your approach to them
- ✓ There's a never ending stream of them
- ✓ Denials reasons can be misleading (cannot make determinations based on 835 data alone)
- ✓ Endless payer variability in Denial Reasons and CAS Code usage
- ✓ Moving target, new rules, new payer requirements
- ✓ Difficult to root out (conclusive determination)
- ✓ Denial solutions will vary in the level of time and effort needed to fix them
- ✓ It can be difficult measuring success
- ✓ On average, Denials continue to account for 10+% of providers gross revenue
- ✓ Denials are resource intensive
- ✓ Most denials are not conducive to daily work-q's
- ✓ Many organizations use denials to point fingers that undermines collaboration and culture.

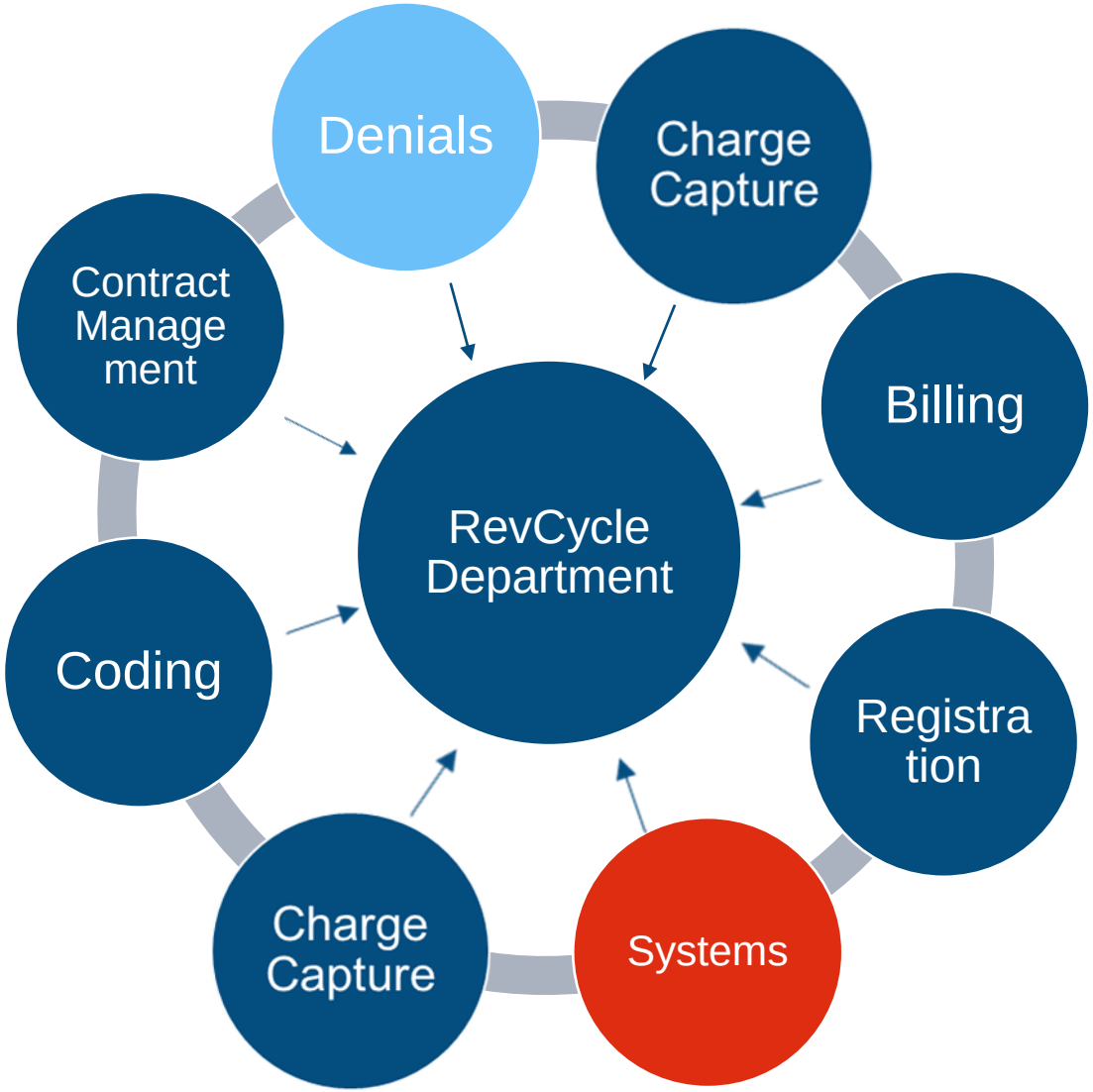
As a result of the 835 and Denial Management

- ✓ Clinical personnel and clinical leadership recognize the importance of their revenue. (I rarely hear “its not my job” anymore)
- ✓ New Department (i.e. Rev Cycle, Revenue Integrity, etc) as a result of Denials and the need to capitalize on all Revenue opportunities. Creation of a completely new department! “Revenue Cycle”, importance of dedicated resources and teams to focus on optimal reimbursement
- ✓ Multi disciplinary approach is necessary. (No single person can be effective with Denials)

Denial Analytics “Then” and “Now”



Revenue Cycle Department



Revenue Cycle Systems - Peripheral Systems

- Appointment Reminders
- Eligibility Verification
- Authorization/Referral
- Encoder (CAC)
- Claims Clearinghouse
- Denials
- Contract Management
- Patient Statements
- Patient Portal
- Case Management

Advanced Denial Analytics

- Using the 835 to identify system set-up issues (QC your primary EMR and Clearinghouse!)
- Measure compliance and quality with the 835
- Use the 835 to reduce the risk of erroneous patient statements
- 835 as a key quality indicator (understanding the importance of CCR (Clean Claim Rate))
- Line level, i.e. HCPCS Code payment validation
- DRG/APC Comparative Analysis

835/Denials = IT Vendors Accountable

Three causes of denials…

1. Missing or Invalid Data
2. Payer requirements related to enrollment and eligibility
3. Compliance and/or Level of Care Justification

Missing or Invalid Data

- Your ‘Systems” should be validating all required data elements needed for payer adjudication?
- EMR should provide “reminders”, “attributes” and “edits” to help support your clean claim rate.
- Utilize your denial data to enhance/optimize your EMR and other key technologies
- If your organization utilizes a Claims Clearinghouse, consider establishing a monthly “Denials” meeting with them to review and determine how they can help bolster their edits to reduce denials, rebilling efforts and reduce AR Days.

Measuring Compliance with the 835

- Medical Necessity Denials represent compliance issues
- Level of Care Denials typically point to process issues, communication breakdowns and inefficiencies in staffing or protocols (i.e. no fluid, real-time technology to communicate with nurses and physicians, off-hours coverage, outsourcing)
- Certain CAS Reason Codes should be tied directly to Medical Necessity and Care Management.
- Denials related to MedNec and Care Management should be used for training, appeals and to justify changes in processes.

Protecting Patient Perception – Patient Balance Validation

- Patient Responsibilities live in the ANSI 835 and available prior to your patient statements.
- Utilize the 835 data to validate Patient Statements prior to delivery
- Total Coinsurance Amount -- sum of the CAS03, 6, 9, 12, 15 & 18 values in the appropriate 2000 loop where CAS02, 5, 8, 11, 14 or 17 equals value "2".
- Total Deductible Amount - sum of the CAS03, 6, 9, 12, 15 & 18 values in the appropriate 2000 loop where CAS02, 5, 8, 11, 14 or 17 equals value "1".

Why aren’t most providers exploiting this data?

Complex data structure can make it difficult to capitalize on these opportunities

The volume of data is extensive and can overwhelm

Both Clinical and Financial staff need to understand the data and what it means to them. Ultimately need to achieving organization wide participation

Staff bandwidth, competing priorities, outsourcing intelligence

Does your Hospital have a Denial Coordinator?

Does your Hospital have a focused Denial Team?

The 835 should is much more than just a rebilling indicator…

- Accelerating delayed reimbursement
- Reduce lost revenue
- Analyzing upstream performance
- Bolster Organization wide fiscal accountability

Questions?

Thank you!

Please feel free to contact me with questions.

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