Leveraging Payer Behavior to Improve Clinical Denials and Appeals Management – a Technology-led Strategy

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MAPAM Annual Fall Conference

Krithika Srivats, MSOTR, Sr. Vice President, Clinical Practice and Products, has been a thought leader in the health care industry deeply, supporting innovation in care delivery. She has >25 years' experience supporting patient care, establishing centers of excellence across the globe in the research and care of people with Alzheimer's disease and dementia. She has also vast experience working on Payer processes for over 15 years. She leads the medical management practice for Sagility Health and directs all automation and analytics development for improving the overturn rates. She has been a speaker In several healthcare conferences and has published thought leadership articles in collaborative care, automation, predictive analytics to improve home-based aging etc., Her deep experience in healthcare resonates in her podcasts and other published articles.

Dan Hillman, Vice President, Revenue Cycle Strategy supporting automation efforts. With over 30 years in the healthcare financial operations, Dan has been part of the evolution of technology in the healthcare finance operations specifically in application of intelligent automation in the healthcare financial operations. He has been a speaker at the HFMA regional and local conferences and has authored articles on reducing the cost of collections and strategies for applying intelligent automation in RCM. His most recent published article is in the February 2020 issue of the hfm magazine.

Agenda

- Business context - Why are clinical denials so difficult to overturn?
- Trends and root causes of clinical denials
- Leveraging analytics and intelligent automation
- Example of tech-enabled denial overturn
- Q&A

Business Context

- **Clinical denials** - typical reason - "Upon clinical review, the patient doesn't meet the plan's criteria for medical necessity or could have been treated in a lower level of care setting."
  - Denied claims usually cost around **$118** in re-work for facility claims and **$25** in re-work for professional claims to process denial
  - Reworking clinical denials can cost **3-4 times** more

Only **20%** of clinical denials get appealed and only **35%** of them get overturned

Hospitals lose approximately **$262B** due to denied claims each year, an average of **$5M** per provider

This constitutes to about **10%** of total claims paid out

Increasing Volume of Clinical Denials

Technology advances flagging multiple dimensions of claims for denial

Global Clinician shortage – less revenue integrity audits

Increasing complexity & newer procedures resulting in more scrutiny

Pre-Service Denials

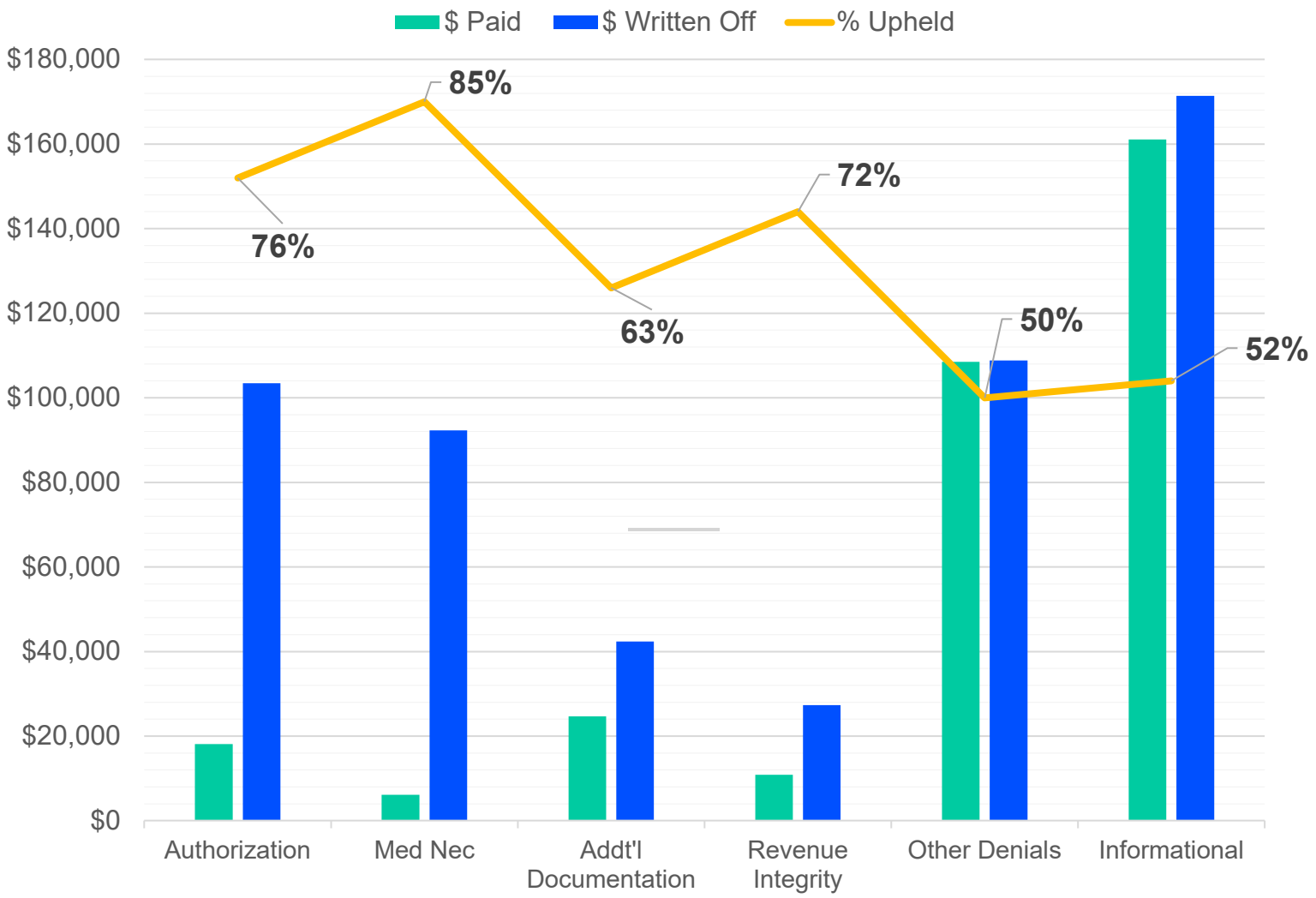
- Increasing focus on observation vs inpatient
- Procedure & guideline-based authorization vs clinical care pathway-based authorizations
- Stat orders lack supporting Medical indication

Post-Service Denials

- Increasing payment integrity analytics
- Clinical audit and validation
- MUE/NCCI denials are rules based denied by technology

~20-22%
increase in clinical denials each year

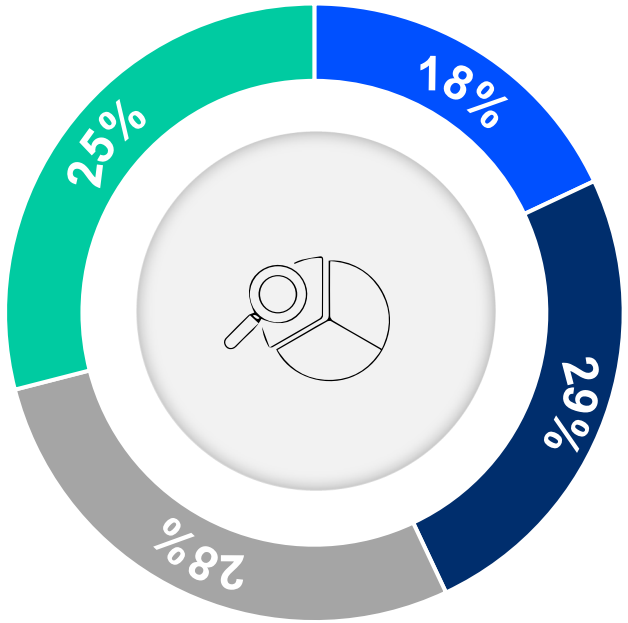
Trends in Clinical Denials
Overturn Rates by Categories



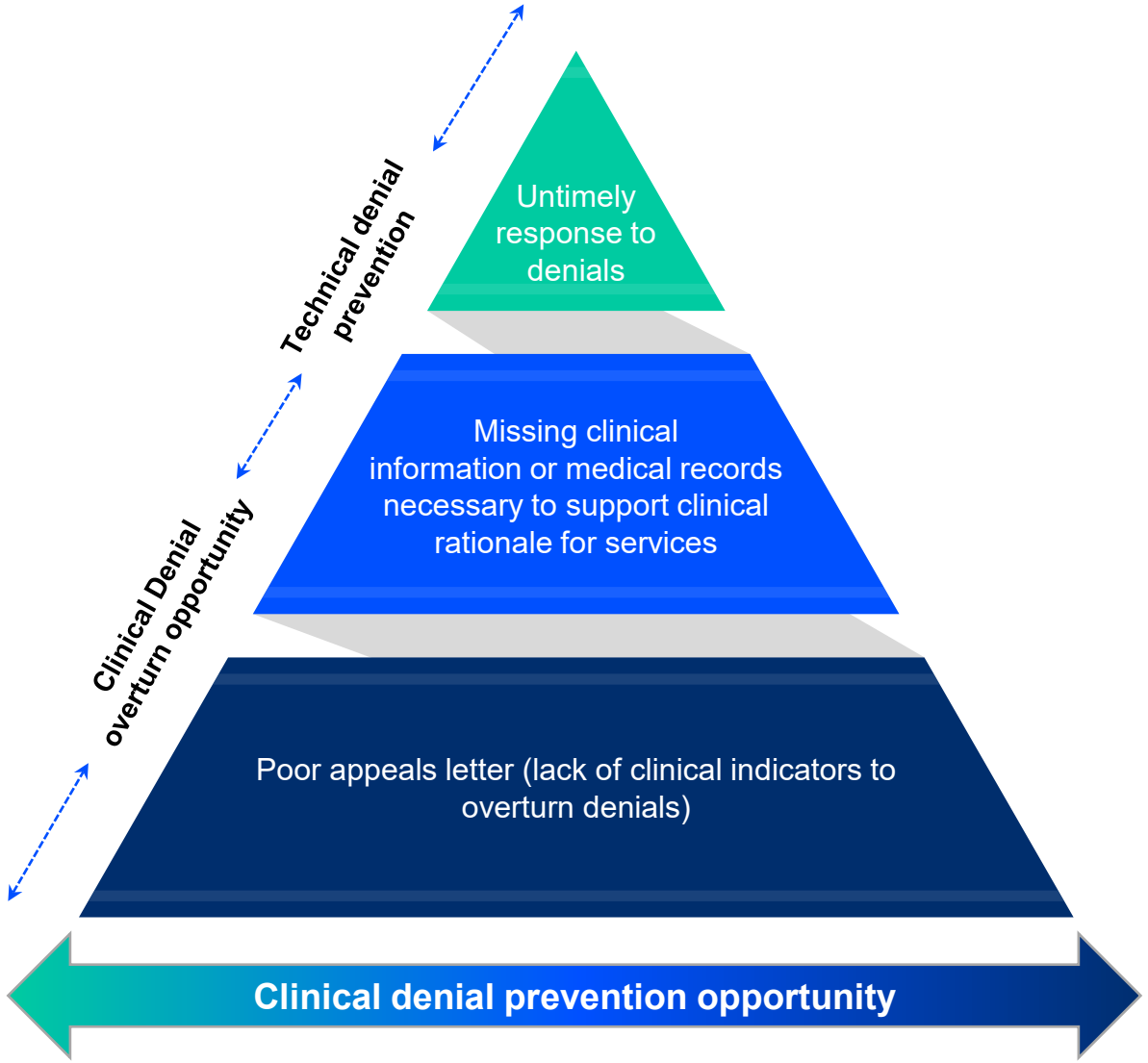
Top denial types

- Authorization denials for lack of medical necessity
- Post service denials due to level of care/ DRG/medical necessity/service did not meet plan's policy
- Behavioral health denials- Typically level of care
- Length of stay denials
- Lack of modifiers
- NCCI/MUE edits
- CPT/HCPCS
- DX issues

Root Cause of Poor Overturn Rates



- Disparate Payer process
- Insufficient resource allocation
- Process breakdown between Revenue cycle and clinical teams
- Poor insights and trend analytics



Four ways to improve clinical denial overturn rates

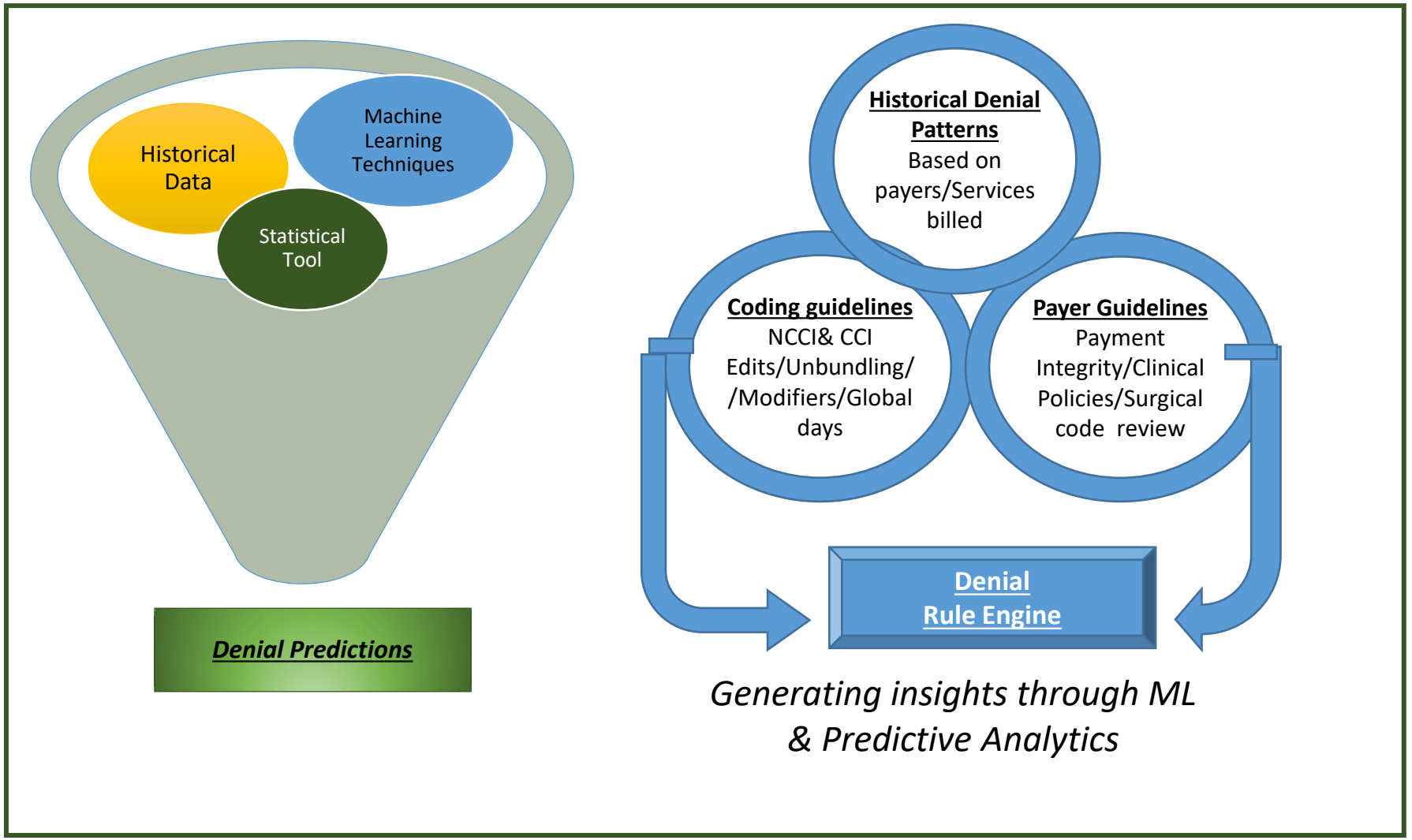
Analytics - predictive analytics and deep business intelligence

Tech-enabled operations

Clinical center of excellence to focus on outcomes

Creating payer- provider synergies

1. Role of analytics in clinical denials program



Faster Cash collection
Reduce incorrect Technical denials

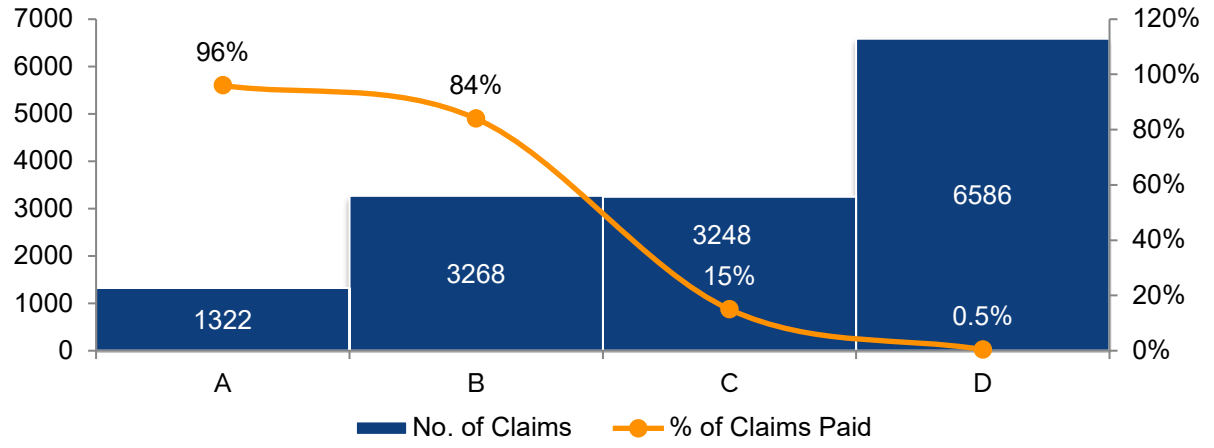
P-Models
P2D & P2OT

Predictive models on propensity to overturn denials based on Payer type, denial type, trends in clinical documentation integrity by provider and clinical criteria

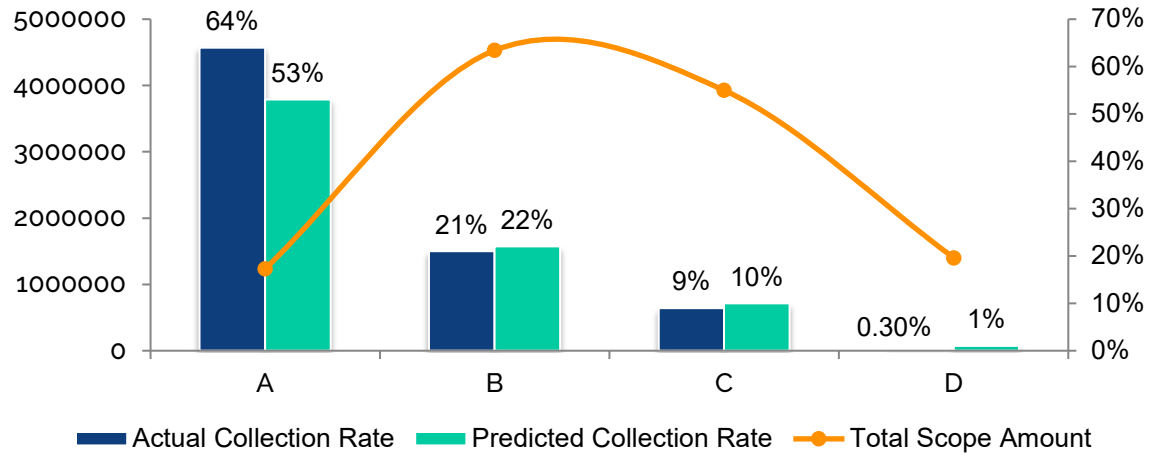
1a. Applying payer domain expertise in predictive analytics – propensity to pay models optimize denial focus

	Bucket	No. of Claims	Distribution	No. of Claims Paid	% of Claims Paid	Total Scope Amount($)	Predicted Paid($)	Predicted Rate of Collection	Actual Paid($)	Actual Rate of Collection
Collectible	A	1322	9%	1277	96%	1236215	663227	53%	792410	64%
	B	3268	22%	2756	84%	4529208	1003546	22%	954604	21%
Non-collectible	C	3248	22%	497	15%	3926118	418765	10%	365490	9%
	D	6586	45%	30	0.5%	1401644	7730	1%	3937	0.3%

Bucket wise - % of claims paid



Actual vs predicted rate of collection



A predictive model that analyses data and recognize patterns

2. Tech Enabled Efficient Clinical Denial Operation

Specialized Routing

- Platform led data flow across
- Provider and vendor solution to receive clinicals and manage the queue
- Categorization based on Dollar, Ageing, Type of denial
- Auto Prioritization
- Auto Skill/Specialty based allocation

Nurse Assist automation

- Initial check on completeness of record
- Evaluates submitted records
- Specialty/Type based Appeal letter templates
- Intelligent Content Processing –for Medical records review
- Summary documentation

Clinical / Coding Criteria Mapping

- Applies programming
- Select Clinical and Coding criteria
- Translates criteria into rules
- Automated rules selection
- Rule based automation

Focused and Tech enabled Audits

- Nurse evaluates summary & recommendation against records
- Records meet or do not meet criteria
- Clinician completes an appeal letter or refer it to Medical Director

2a. Applying Intelligent Automation to improve Nurse Productivity

Technology Incorporation

- OCR
- NLP
- Machine Learning
- Predictive Model

Clinical / Coding Criteria Mapping

- Maps clinical criteria
- Translates criteria into rules
- Applies programming
- Utilizes relevant technology assist

Process Automation

- Evaluates submitted records against automated rules
- Provides summary to nurse if records meet or do not meet criteria

Outcome

- Nurse evaluates summary & recommendation against records
- Nurse approves case or pends case to Medical Director

Bot review sample - approval capsule endoscopy denial review

Colonoscopy, 10/1/2018, Normal mucosa in the whole colon and Grade/Stage I internal hemorrhoids

2017

EGD, 10/1/2018, Erythema, friability and erosions in the gastroesophageal junction compatible with erosive esophagitis. (Biopsy), Mucosa suggestive of Barrett's esophagus (Biopsy), Erosions, erythema and friability in the antrum compatibly with antral gastritis, (Biopsy) and Ulcers in the duodenal bulb and second part of the duodenum, (Biopsy)

EGD CDE, 4/9/2019, Esophageal hiatal hernia, Mucosa suggestive of Barrett's esophagus (Biopsy), Granularity and erythema in the stomach body and antrum, (Biopsy) and Normal mucosa in the whole examined duodenum

Past Surgical

Pacemaker	**08/14/2020**
Colonoscopy	08/14/2020
EGD (43235)	08/14/2020
Appendectomy	08/14/2020
Cholecystectomy	08/14/2020

Criteria Rule Feedback = 1st Indication Met

- Anemia history with unknown cause

Criteria Rule Feedback = 2nd Indication Met

- No evidence of bleeding in Colonoscopy and EGD

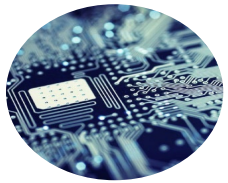
Criteria Rule Feedback = LCD Limitation found for procedure

- History of pacemaker placement

Image Output

- Indications met highlighted in records

3. Clinical COE to drive better outcomes



IRR – Clinician

- Completeness of record
- Skill based allocation
- Machine Learning
- Predictive Model

Calibration of Appeals (1st/2nd Level)

- Appeal based on specific guideline followed by payer
- Regular recalibration with provider
- Check on latest clinical guidelines

Latest Trends in patient Care

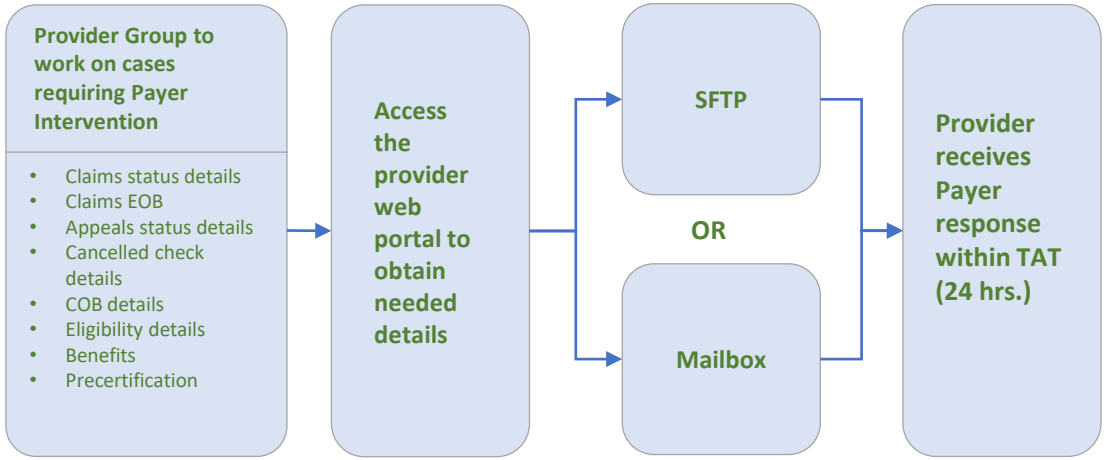
- Internal Medical director review
- Peer to Peer Audits
- Round table discussion
- Clinical COE practice guidance
- Clinical Coaching

Alignment to Payor trends and committee

- Keep updated with the payor trends on decision making
- Sharing best practices
- Updated clinical guideline on some of the common services/conditions

4. Payer-provider synergy–alternate channel

PROCESS IMPROVEMENT:



Reduced call duration

Reduced Repeat calls

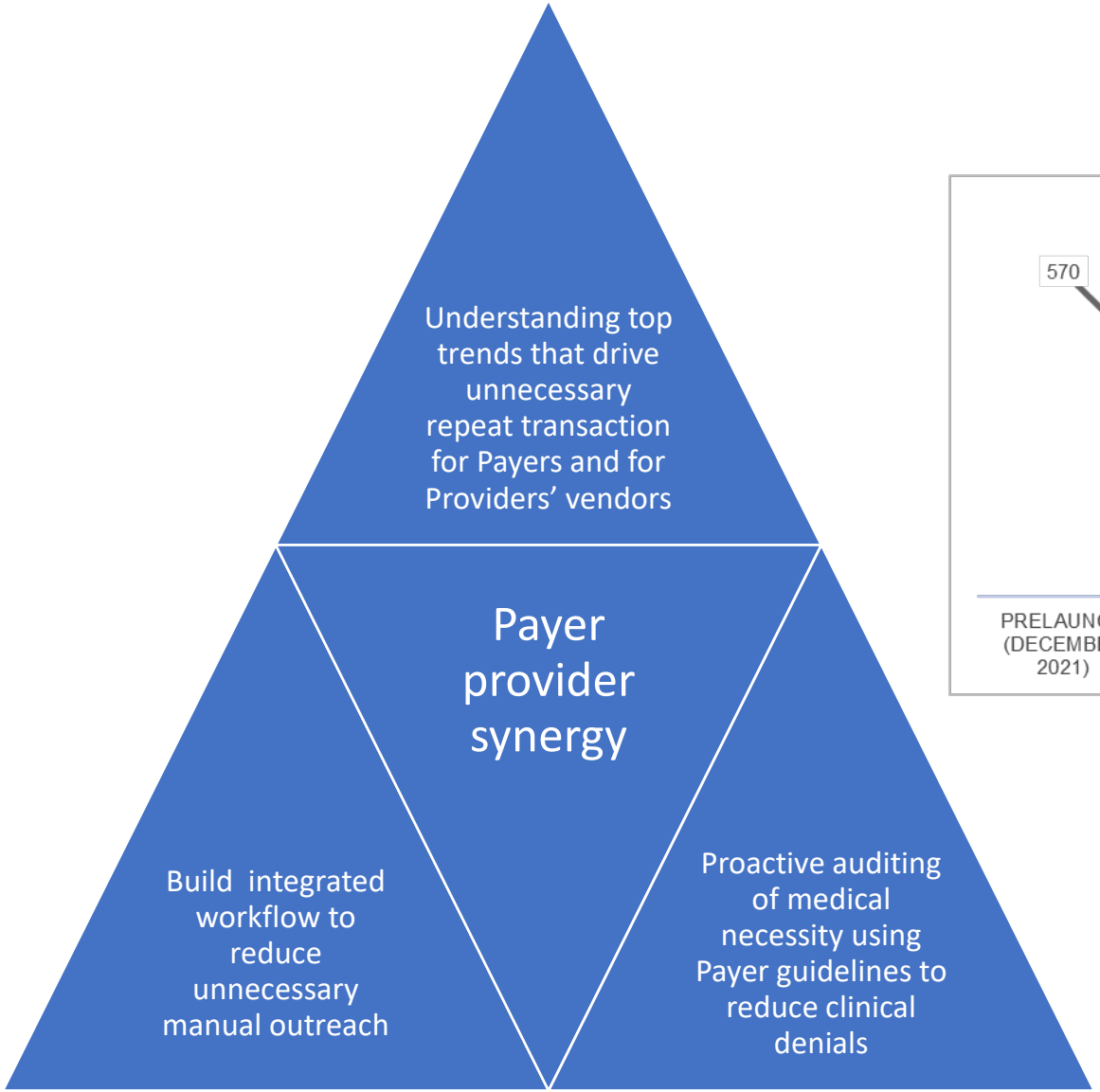
Case aging prioritization

Optimize staff Occupancy

POTENTIAL BENEFIT:

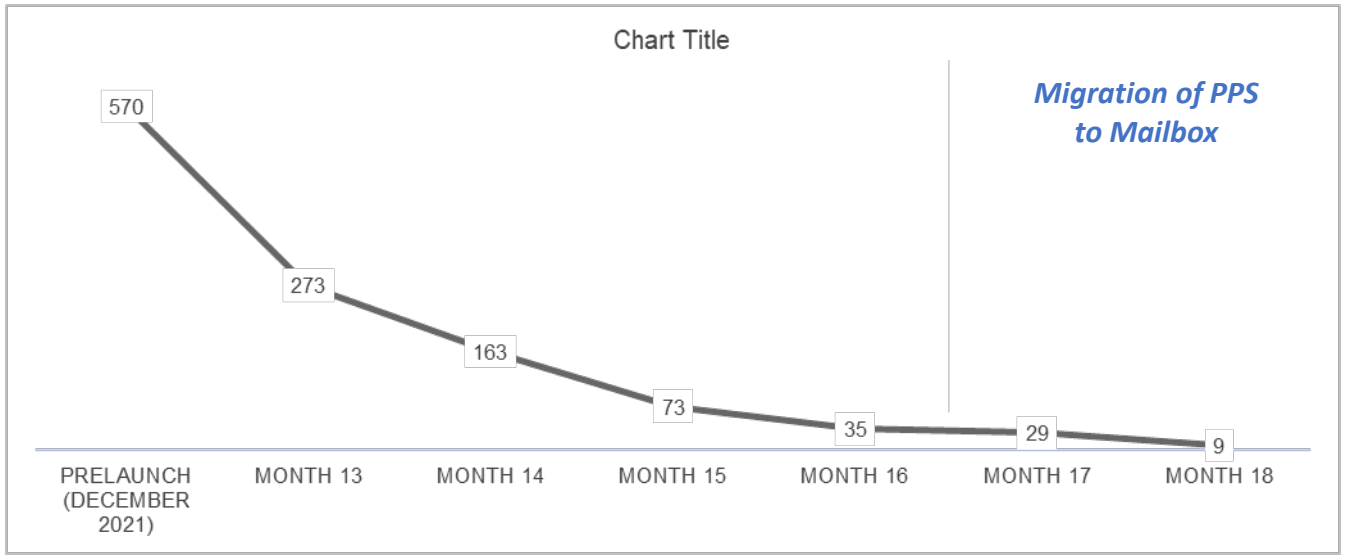
- Reduced multiple patient and inquiries calls to the call center
- Reduced Provider effort and improved experience with specific payer cases
- Insights to improve web portal (Availity) functionality and utilization
- Reduced repeat calls - cases are processed and resolved holistically
- Opportunity to manage and optimize staff to work offline during non-critical intervals

Results of Payer Provider alternate channels



98% reduction in repeat transactions

Average monthly calls reduction



4a. Revenue integrity (RI)-using AI to detect underpaid claims

- Identify the underpaid or not charged or to be reimbursed Claims etc. using in built queries for each scenario.
- Every scenario is developed by a set of rule(s) based on which the qualified claims are identified, and the possible next action to be performed
- These revenue integrity scenarios are built in to match the criteria in line level details of Claim information.
- All the Claims which are qualified are highlighted for Agents to revisit/rework and sent it back to payers for re-imbursement or for re-billing or reappeal etc.

Results from a robust clinically focused, automation and analytics led solution leveraging payer behavior insight

- Increase in the # of hospitals we support with clinical denials
  - Started with 2 hospitals doing only OP denials
  - Currently handling fifteen hospitals. Appealing for OP/IP/BH/PA Denials/All specialties/Coding
- Collection increase YOY
  - Increased collection by 30% YOY
- Overturn percentage month on month
  - Overturn rates are at 60-70% each month for some hospitals at 72%
- Cost of Operations reduced by 23%
  - Automation of clinical review
  - Enhanced predictive analytics
- Additional scope
  - Added second level appeals with overturn rates of 20% higher than baseline

NET OVERTURN RATE FOR 13 HOSPITALS
68.5%

Thank You

For more information, call **Dan Hillman:**

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Case Study

Payer-Provider Synergy

The Sagility Provider RCM team is contracted with different provider groups to process and resolve accounts receivable (A/R) cases. The Provider RCM team would use resources available such as accessing Payer's web portal and predominantly calls are made to the Payer contact center to gather the required information to complete the A/R cases.

OBJECTIVE

- Resolve the unworked and aging cases: 80% of cases are have either been unworked or aging for 31+ days without required details to resolve

OUR SOLUTION

- Creation of required templates to accommodate data inputs from Provider group and details required from Payer to resolve the A/R case
- SFTP site to transfer files containing PHI data
- Created SOPs and workflows to support offline case completion – documenting required documentation process in both CRM and agreed template
- Identification of required staff to handle case inflow and off the phone time schedule to optimize occupancy and line adherence

BENEFITS

- Productivity of **7 cases per hour with 97% compliance with TAT**
- Of the cases received, **87% were successfully completed – of which 96% were cases that were either unworked or aging for 31+ days.**
- 98% First Touch Resolution
- 86% decrease in calls to the contact center in the first month post-implementation
- Paved way in **establishing Provider Mailbox,** to increase Provider participation and pool

Provider Payer Synergy – Contd-

- To manage the accounts which need information/status/details from the payor- Automation setup to send an auto email via secured mailbox to payer.
- Accounts which has inquiry details to be received from Payer are identified and claim details to be sent to Payer are extracted and collated to a pre-defined excel template by end day.
- Excel file with extracted data is attached to an auto-email drafted in payer mailbox and sent to pre-configured payer mail group.
- The Payer replies to the same email with attachments needed and the requested details filled in the same Excel template on or before 7 days of TAT. Once the response email is received, the automation will auto-index the received attachments, if any, to the respective claim correspondences and based on which next action can be taken
- If no response is received from Payer on or before 7 days, then the accounts will be recoded and resent to Payer as part of automated email for details.