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"YOU'VE BEEN DENIED"

February, 16 2018

TODAY'S DISCUSSION

- **Utilizing Denials as a Revenue Cycle Diagnostic Tool**
- **Denials Management is more than a Back-office Function**
- **Benchmarking**
- **Denials Evaluation & Program Implementation**

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DENIALS OVERVIEW

Denials & Underpayments

Denials - What are they?

- Insurance companies deny paying benefits for a variety of reasons that are sometimes misleading, often incorrect and occasionally done in bad faith, but more times than not it is a result of poor provider revenue cycle processes.
- Denials typically occur as a result of operational inefficiencies, payer errors, or not complying with contractual arrangements. Claim denials directly impact 5%-9% of net revenue with approximately 50% of this amount lost each year. A significant amount of time, effort, and cost is involved in reworking claims, sending appeals, and collecting the remaining 50% of denials.

Underpayments - What are they?

- Insurance companies sometimes do not reimburse at a level consistent with agreed-upon contractual rates. This is sometimes unintentional or could be purposeful - “payer shaving”.
- Managing complex payer contracts, coupled with the lack of formalized contract management tools, creates the potential for substantial underpayments.
- Between 5% to as much as 14% of a provider’s contracted revenue is impacted by underpayments and the difference is frequently mistaken for, and recorded as, a contractual adjustment.

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DENIALS OVERVIEW

How are Denials Communicated?

A facility usually learns of an insurance claim denial via the Explanation of Benefits (EOB) remittance statement. The EOB will usually contain an itemization of covered, non-covered, and denied charges as well as a set of corresponding remittance codes (ANSI standard or codes unique to the payor) that refer to a guide either on the bottom or the back of the statement. These explanations are difficult to interpret, even by those in the field, and should not necessarily be taken at face value or as the final word.

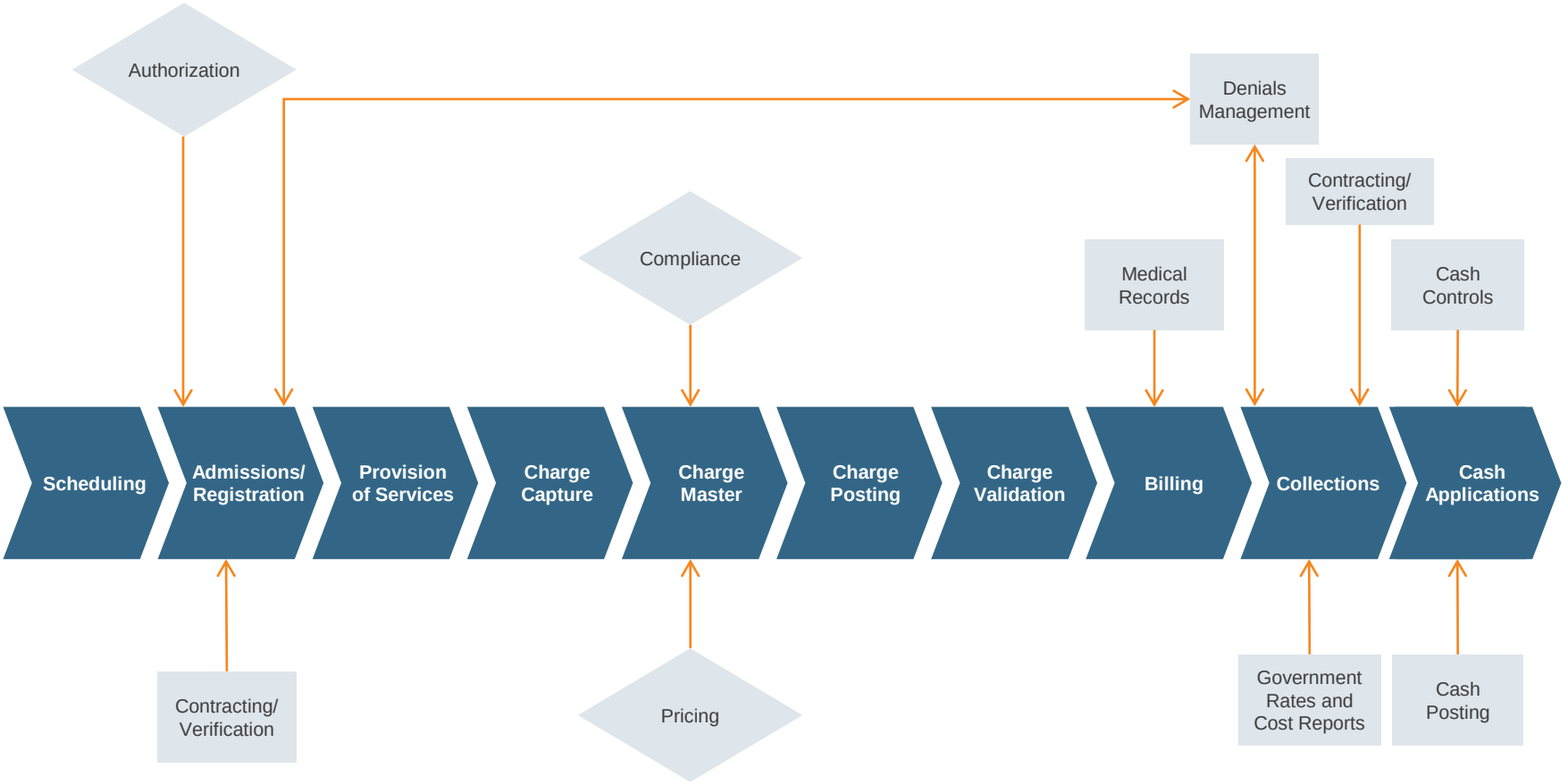
The **835** is the American National Standards Institutes (ANSI) Health Care Claims Payment and Remittances Advice electronic standard format. HIPAA requires the use of 835 or an equivalent by all payors. A national remittance code maintenance committee maintains the standardized 835 remittance codes. These standard ANSI codes are listed on (http://www.wpc-edi.com/codes):

- **Claim Adjustment Reason Codes (CARCs):** Communicate why a claim or service line was paid differently than it was billed.
- **Remittance Advice Remark Codes (RARCs)**: Communicate additional explanation for an adjustment already described by a CARC, or convey information about remittance processing.

ONE OF THE BEST INDICATORS TO HELP DETERMINE THE EFFECTIVENESS OF A PROVIDER'S REVENUE CYCLE IS TO LOOK AT DENIED (AND REJECTED) CLAIMS!

DENIALS AS A REVENUE CYCLE DIAGNOSTIC TOOL

Deficiencies and avoidable mistakes in key revenue cycle components undermine the effectiveness of a healthcare provider's revenue cycle. Healthcare providers typically fail to realize as much as 5% in net revenue due to a lack of effective internal controls mitigating financial, regulatory, and operational risks.



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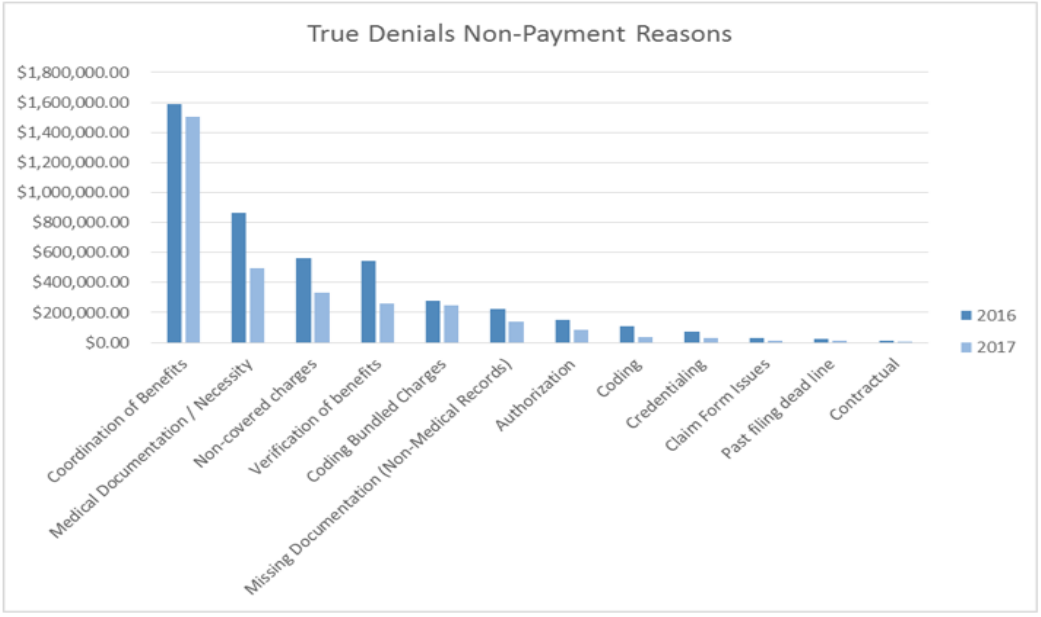
DENIALS AS A REVENUE CYCLE DIAGNOSTIC TOOL

Denials Analysis

Overall Summary	2016			2017		
	Amount/CPTs Charged	True Denials	Rate	Amount/CPTs Charged	True Denials	Rate
Denial Rate $ (True Denial / Charges)	$44,098,515.16	$4,469,858.79	10.14%	$33,159,258.46	$3,155,619.47	9.52%
Denial Rate CPT (Count of True Denial CPT / Count of Charge CPT)	376671	87783	23.30%	236728	30579	12.92%



True Denials - 2016		
Non-Payment Reason	Adjustment Amount	Adjustments as % of Gross Charges
Coordination of Benefits	$1,587,150.34	3.60%
Medical Documentation / Necessity	$861,770.95	1.95%
Coding Bundled Charges	$562,145.81	1.27%
Verification of benefits	$546,253.88	1.24%
Non-covered charges	$281,350.47	0.64%
Missing Documentation (Non-Medical Records)	$225,884.27	0.51%
Coding	$149,146.98	0.34%
Authorization	$107,310.77	0.24%
Past filing dead line	$75,303.33	0.17%
Credentialing	$33,884.00	0.08%
Claim Form Issues	$27,631.00	0.06%
Contractual	$12,026.99	0.03%
Grand Total	**$4,469,858.79**	**10.14%**

True Denials - 2017		
Non-Payment Reason	Adjustment Amount	Adjustments as % of Gross Charges
Coordination of Benefits	$1,503,331.97	4.53%
Medical Documentation / Necessity	$492,938.25	1.49%
Non-covered charges	$334,975.86	1.01%
Verification of benefits	$259,169.17	0.78%
Coding Bundled Charges	$248,072.64	0.75%
Missing Documentation (Non-Medical Records)	$138,263.74	0.42%
Authorization	$84,178.96	0.25%
Coding	$39,731.12	0.12%
Credentialing	$32,151.00	0.10%
Claim Form Issues	$11,895.85	0.04%
Past filing dead line	$10,003.03	0.03%
Contractual	$907.88	0.00%
Grand Total	**$3,155,619.47**	**9.52%**

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DENIALS AS A REVENUE CYCLE DIAGNOSTIC TOOL

Denials Analysis

Non Payment Reason	Adjustment Code	Reason Description	Adjustment Amount - 2016	Adjustment Amount - 2017
Coordination of Benefits	OA23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	$1,490,367.02	$1,452,594.82
	OA22	This care may be covered by another payer per coordination of benefits.	$34,616.35	$18,803.50
	CO23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	$42,057.38	$0.00
	PR22	This care may be covered by another payer per coordination of benefits.	$19,069.59	$11,207.93
	CO22	This care may be covered by another payer per coordination of benefits.	$840.00	$19,825.71

Non Payment Reason	Adjustment Code	Reason Description	Adjustment Amount - 2016	Adjustment Amount - 2017
Medical Documentation / Necessity	CO50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$338,590.01	$197,110.00
	CO59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$282,704.27	$155,047.70
	PR50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	$66,900.62	$46,601.20

Non Payment Reason	Adjustment Code	Reason Description	Adjustment Amount - 2016	Adjustment Amount - 2017
Verification of benefits	PR31	Patient cannot be identified as our insured.	$140,655.97	$82,494.16
	PR119	Benefit maximum for this time period or occurrence has been reached.	$106,060.80	$11,870.24
	CO109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	$63,664.01	$50,379.05
	PR27	Expenses incurred after coverage terminated.	$58,193.64	$45,835.70
	OAB11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	$67,938.11	$14,234.00

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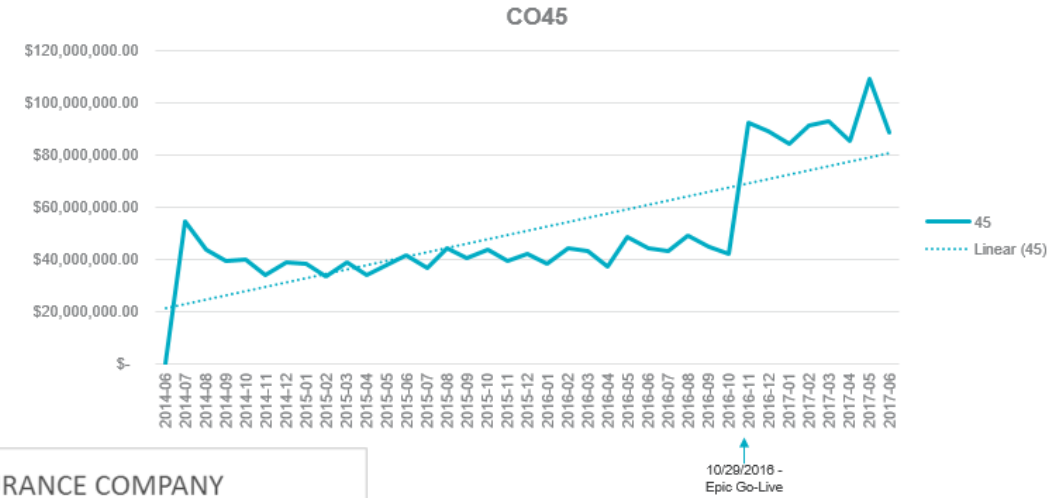
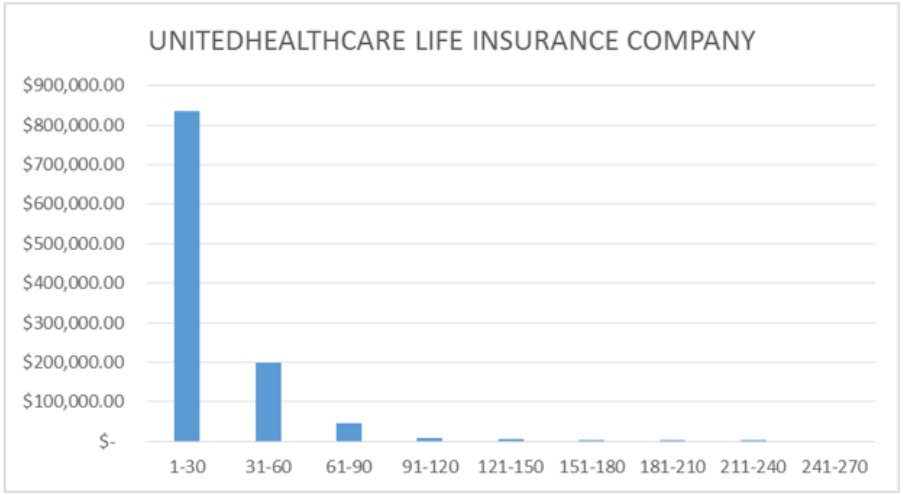
DENIALS AS A REVENUE CYCLE DIAGNOSTIC TOOL

Other 835 Analytics

835 ADJUSTMENT ANALYSIS FOCUSING ON CO45

- CO45 remark codes represent a fee schedule or contract adjustment.





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MANAGING DENIED CLAIMS

The vast majority of all denials determined unrecoverable can be prevented with improved controls in upstream processes.

Organizations should strive for total denials to be less than 3 percent of revenue, with a denial-related bad debt write-off rate of less than 0.5 percent of revenue.
An effective overturn rate is 50% or better.

The denials management process is generally perceived as a back-end financial function. But it should be viewed as an end-to-end revenue cycle process involving business process re-engineering, system enhancements and training initiatives.

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What is Denials Management?

Denials management is the process of collecting, tracking, reporting, trending, forecasting, measuring, and managing denied claims. This process may include, or require, specially designed tools (e.g., databases, etc.). To effectively manage denials, an organization must focus on those activities and processes that impact denied claims (i.e., the patient revenue cycle).

Realized opportunities for increasing hospital patient revenues and preventing future revenue loss have produced the business case for providers to dedicate the necessary resources for denials management. Denials management can be a powerful source of improved revenues.

An **effective** denials management program enables healthcare providers to better manage one of their most expensive business risks, resulting in:

- Identification of key reasons for revenue loss
- Detailed denials tracking and appealing procedures developed
- More effective and efficient processes
- Reduced denial volume and improved A/R
- Improved patient satisfaction
- More integration and enhanced communication between internal departments

What is Denials Management? – Monitoring and Trending

Sample Reports and Dashboards

Effective denials management includes adequate reporting and trending to identify root causes of denials and also measure the effectiveness of the appeals process.

		Denied, Reworked & Collected		Denied & Written Off or Unrecovered		Total Denied in Reimbursement Process	
`	IP	$ -		$ 1,728,898		$ 1,728,898	
	OP	$ -		$ -		$ -	
	ER	$ 16,136		$ 3,315		$ 19,451	
			$ 16,136		$ 1,732,213		$ 1,748,349
Medicaid	IP	$ 798,221		$ 1,506,604		$ 2,304,825	
	OP	$ 61,218		$ 14,482		$ 75,699	
	ER	$ 9,940		$ 2,554		$ 12,494	
			$ 869,379		$ 1,523,639		$ 2,393,018
Medipak HMO	IP	$ -		$ 300		$ 300	
	OP	$ 124,948		$ -		$ 124,948	
	ER	$ -		$ -		$ -	
			$ 124,948		$ 300		$ 125,248
Blue Cross	IP	$ 1,356,890		$ 48,229		$ 1,405,119	
	OP	$ 51,574		$ 216,046		$ 267,620	
	ER	$ 85,144		$ 7,126		$ 92,270	
			$ 1,493,608		$ 271,401		$ 1,765,009
Commercial	IP	$ 813,503		$ 4,544,719		$ 5,358,221	
	OP	$ 3,154,224		$ -		$ 3,154,224	
	ER	$ 598,225		$ 222,683		$ 820,908	
			$ 4,565,952		$ 4,767,402		$ 9,333,354
Net TBC			**$ 7,070,023**		**$ 8,294,954**		**$ 15,364,977**

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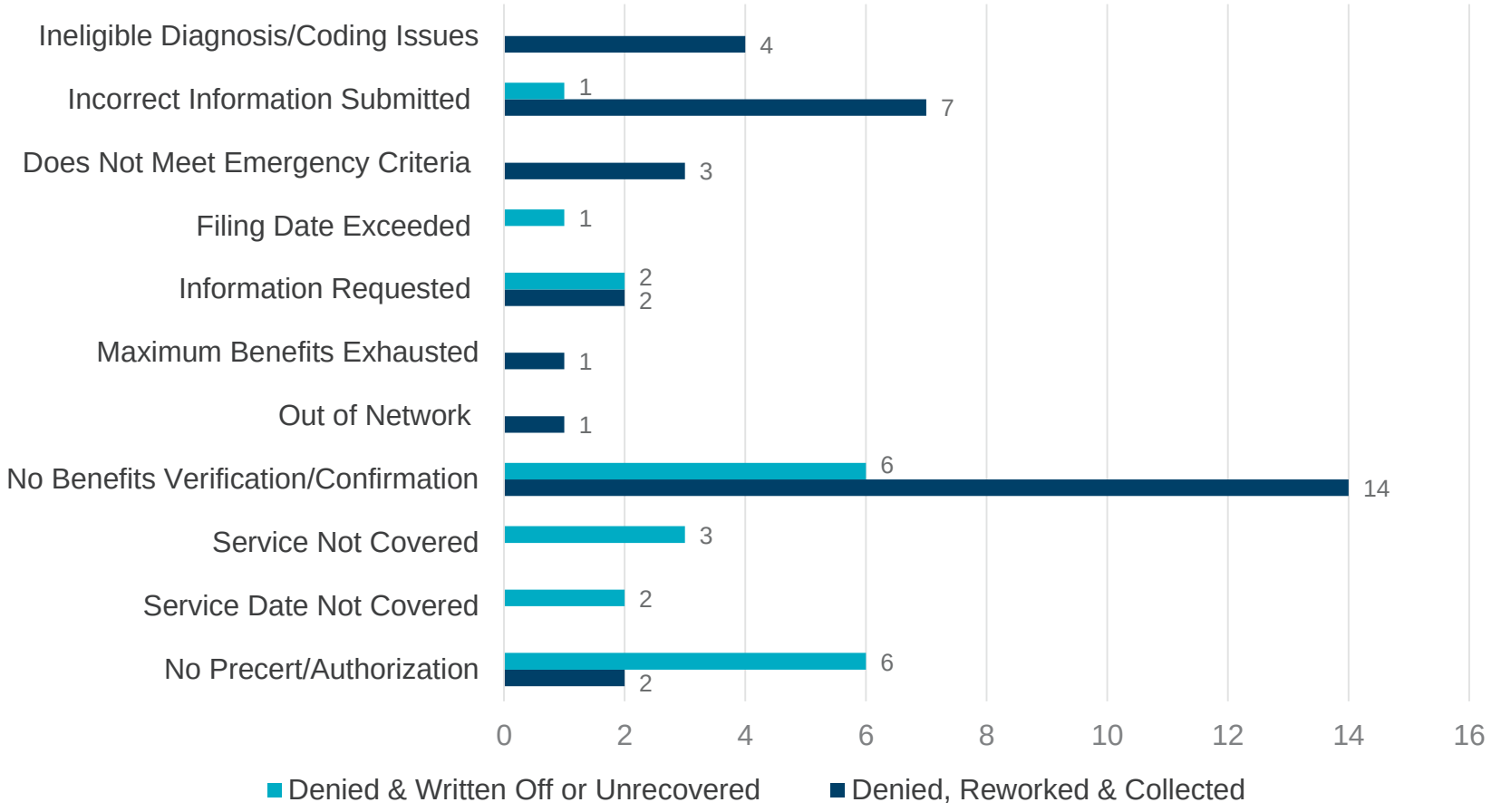
What is Denials Management? – Monitoring and Trending

Sample Reports and Dashboards



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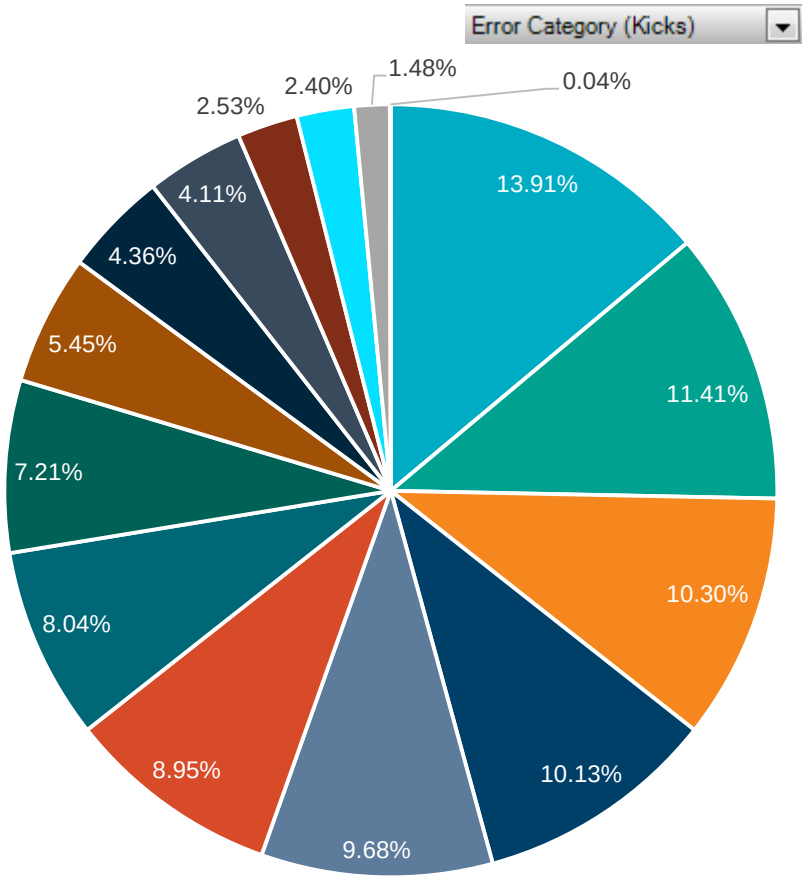
What is Denials Management? – Monitoring and Trending

Sample Reports and Dashboards

	Denial Dollars	%
Patient Insurance Issues	$6.793K	13.91%
Provider Information	$5.571K	11.41%
Additional Documentation Required	$5.030K	10.30%
Benefits Coverage	$4.946K	10.13%
Coding	$4.724K	9.68%
Medical Policy	$4.370K	8.95%
Referral/Authorization	$3.925K	8.04%
Denied - not specific	$3.522K	7.21%
Credentialing	$2.661K	5.45%
Coordination of Benefits	$2,127K	4.36%
Billing Deadline Exceeded	$2.007K	4.11%
Claim Data	$1.234K	2.53%
Format	$1.171K	2.40%
Patient Demographics	$723K	1.48%
Service Contract	$19K	0.04%



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BENCHMARKING

Key Denials Metrics and HFMA Industry Standards

Healthcare Financial Management Association (HFMA) defines the clinical initial denials rate to be less than 5% and the technical initial denials rate to be less than 3% with a combined overall initial denials rate not to exceed 4%. HFMA also establishes the denials overturned by appeal rate as 40% - 60%. Best practice organizations have been able to achieve an overall denials write-off rate less than 0.5% on a consistent basis. Additional Denials KPIs are provided on this slide. It is important to note that as more Physician Organizations emerge across the industry, HFMA will be able to refine and identify additional physician clinic denials KPIs.

Hospitals and Health Systems: Denials KPIs	Target
Overall denials rate as a percent of gross revenue	≤ 4%
Clinical denials rate as a percent of gross revenue	≤ 5%
Technical denials rate as a percent of gross revenue	≤ 3%
Rate of additional collection for underpayments	≥ 75%
Rate of appeals overturned	40 – 60%
Electronic eligibility rate	≥ 75%
Physician pre-certification double-check rate	100%
Case managers' time spent securing authorizations rate	≤ 20%
% of high-revenue managed care contracts modeled (80/20 rule)	100%
Total denial reason codes	≤ 25
Initial Zero Paid Denial Rate	≤ 4%

Physician Organizations: Denials KPIs	Target
Overall initial denials rate (% of gross revenue)	≤ 4%
Clinical initial denials rate (% of gross revenue)	≤ 5%
Technical initial denials rate	≤ 3%
Underpayments additional collection rate	≥ 75%
Appealed denials overturned rate	40-60%
Electronic eligibility rate	≥ 75%
Physician pre-certification double-check rate	100%
Case managers' time spent securing authorizations rate	≤ 20%
Total denial reason codes	≤ 25%

APPENDIX - REFERENCE MATERIALS

DENIALS EVALUATION (1/2)

Evaluating Denials and Denials Management Programs

Denials Testing

Testing & Testing Attributes specific to testing denials:

- Determine sampling approach; given the frequency of denials and zero-payment transactions, sample size is generally between 35-60 accounts or denied line items across accounts
  - **Known Denials:** Judgmentally select a sample of denied claims, and use source EOB / ERA and Patient Accounting System (PAS) notes to test the following:
    - Appropriate identification (i.e., manually by personnel or electronically interfaced), recoding, and classification of the denial
    - Appropriate and timely appeal actions taken by financial services staff
    - Appropriate final adjustment decision:
      - Amount adjusted / written-off (W/O) as a denial or contractual
      - Appropriate management approval for W/O per dollar amount thresholds
      - Transfer to next responsible party (e.g., patient, secondary insurance, etc.)
  - **Zero-payments:** Remove any claims identified within the known denials population and judgmentally select a sample of "clean" zero-pay claims. Use source EOB / ERA notes to determine whether any denials were received from the payor but not coded correctly as a denial within the PAS
- Note exceptions and follow up appropriately

Considerations:

- Training around the patient accounting and billing system may be necessary.

DENIALS EVALUATION (2/2)

Evaluating Denials and Denials Management Programs

Denials Management Program Assessment

Assessing Denials Management via departments experiencing high denials:

- Surveying departments experiencing high denials:
  - "What feedback do you receive on a regular basis regarding departmental denials?"
  - "What denials statistics are communicated to you?"
  - "Do you know your department's denial rate?"
  - "What are the most significant/most frequent denials experienced by your department? What causes these denials?"
  - "Have any initiatives been undertaken to prevent denials/resolve issues resulting in denials within your department?"
  - "What is your role in resolving denials?"
- Ensure feedback exists between CBO and:
  - Patient Access Functions
  - Case Management / UR Functions
  - Physicians / Clinical Staff
  - Revenue Integrity

DENIALS PROGRAM IMPLEMENTATION

Achieving Best Practice

Denials Management Implementation Plan

- Develop Denials Management Policies, Procedures, and Guidelines.
- Access 835 Data Transactions and continually work with Payers to process as many claims as possible electronically.
- Establish a denials management function or team, with a designated Appeals and Denials Unit, responsible for meeting on a regular basis to review denials being experienced and to address known issues.
- Establish a standard list of denials reasons to be tracked and reported and map payer codes accordingly.
- Track and report “All” denials/rejects.
- Define Reports - Create reports that will quantify the financial impact of denials received by the organization. (The reports should be categorized in a way that allows management to accurately identify and target areas that may require further enhancement.)
- Develop Feedback Loops and “As Needed” Training based on the denials experienced.

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