Path to Success in Proactive Denials Management & Prevention

Glen Reiner, nThrive
Goals for our time together today

- Industry trends for consideration
- Why Charge Capture matters as we progress to new payment methodologies
- Common Denial problems
- Analyze Denial data
- Strategize continual improvement
Industry overview and market trends

- Increased managed care as percentage of payor mix
- Shift towards bundled and episodic payment
- Increased focus on pricing and charge practices
- Increased regulatory scrutiny and fines

Where should you begin?
Charge, CDM, Denial and reimbursement data

- 1% of net patient revenue is lost due to charge capture errors
- $3.5M in revenue at risk for a median hospital
- -0.7% median operating margin for 200+ bed hospital
- 25% of claims are rejected or denied due to charge-related issues
The REAL industry overview and market trends
Does it really matter in the new world?

REVENUE CAPTURE THROUGH CHARGE AUDIT
Where are charges missed or lost?

- Charge & Order entry
- Staff
- Supplies & Pharm
- ED
- Observation
- Surgery
Why is charge capture important?

- Improves financial performance
- Quantifies resource needs
- Minimizes compliance and audit risk
- Integral component of patient satisfaction
Why is charge capture important?

☑️ Improves financial performance

**Perception:** Charges don’t “matter” in a value-based payment environment (case rate, DRG, etc.).

**Reality:** Charge-based reimbursement is far from gone and still an important portion of hospital revenue cycle.

“Identifying and correcting missed trauma charges in our Emergency Department had a greater than $2M impact to the bottom line in the first year.”

—Director of Revenue Integrity at a 520-bed urban acute care hospital
Why is charge capture important?

- **Drives quantification of resource needs**

  **Perception:** Charges are not a significant consideration or part of resource and cost tracking.

  **Reality:** Charges are the basis for—or are very impactful in—most productivity and cost accounting processes.

REAL IMPACT

“Accurate charge capture is part of our risk assessment in population health… especially in services that underlay that population.”

—Director of contracting at a 29-hospital not-for-profit health care system
Why is charge capture important?

- Minimizes compliance and audit risk

  Perception: Charge capture is solely a gross revenue concern with minimal impact to compliance while “coding” drives my compliance and audit risk.

  Reality: Accurate charge capture and accurate coding are tied together. A comprehensive Charge Capture Program will catch the risks missed by many “scrubbers”.

REAL IMPACT

Total observation hours equaling the time the patient arrived in observation until the patient left observation, along with separate procedures charged with corresponding coding is an indication that the hospital is overcharging observation hours.
Why is charge capture important?

☑️ Integral component of **patient satisfaction**

**Perception:** Patients with any coverage do not care about the itemized bill.

**Reality:** Patients might not think about how their charges are captured but they do appreciate when the provider utilizes charge capture audit to produce an accurate and simplified statement of services.

REAL IMPACT

“My old bill was long and difficult to understand. There were duplicative, miscellaneous, and just too many charges to sort through to try and understand what happened during my hospital stay. My bills are now much clearer, my wife and I can easily understand what care I received and how our Medicare dollars were spent.”

—Patient at mid-sized not-for-profit health care system
Broader implications of charge audit

Charges serve as **currency** for future bundled payment environment

Algorithm for calculating Medicare’s acute care inpatient payment

*For a case with full length of stay*

- **Labor component** of operating cost of base case
- **Adjustment for geographic hospital wage index**
- **Non-labor related costs of base case**
- **Base rate adjusted for geographic factors**

  
  - **Base rate adjusted for geographic factors**
  - **MS-DRG weight**
  - **Adjusted payment rate**

  
  - **Adjusted payment rate**
  - **Indirect medical education payment**
  - **Disprop. share (DSH) payment**
  - **Payment for this MS-DRG at this hospital**
  - **(Possibly) high-cost outlier payment**
DENIALS
Understanding the industry trend

$3 trillion claims submitted
> $262 billion denied, averaging almost $5 million per hospital

Industry average denial rate between 5-10%

65% of claims denials are never re-submitted

31% of hospitals manage denials manually

> 60% without an external solution but plan to purchase one in the next 7-12 months

The MGMA found only 35% of providers appeal denied claim
Denials occur and should be prevented throughout the revenue cycle

Revenue Cycle Opportunities for Denial Prevention

<table>
<thead>
<tr>
<th>Scheduling</th>
<th>Access</th>
<th>Patient Care</th>
<th>HIM, Charge Capture</th>
<th>Billing / Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit plan coverage</td>
<td>• Benefit plan coverage</td>
<td>• Medical necessity</td>
<td>• Documentation</td>
<td>• Bundling</td>
</tr>
<tr>
<td>• Benefit maximums exceeded</td>
<td>• Benefit maximums exceeded</td>
<td>• Authorization</td>
<td>• Medical necessity</td>
<td>• Coding</td>
</tr>
<tr>
<td>• Eligibility</td>
<td>• Coordination of benefits</td>
<td>• Experimental procedure</td>
<td>• Experimental</td>
<td>• Demographic mismatch</td>
</tr>
<tr>
<td>• Experimental procedure</td>
<td>• Eligibility</td>
<td>• Documentation</td>
<td>procedure</td>
<td>• Documentation</td>
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<tr>
<td>• Authorization</td>
<td>• Experimental procedure</td>
<td>• Authorization</td>
<td>• Authorization</td>
<td>• Eligibility</td>
</tr>
<tr>
<td>• Pre-existing condition</td>
<td>• Authorization</td>
<td>• Benefit plan coverage</td>
<td>• Benefit plan coverage</td>
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<td>• Pre-existing condition</td>
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<td>• Coding</td>
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<tr>
<td>• Credentialing</td>
<td>• Medical necessity</td>
<td>• Medical necessity</td>
<td>• Pre-existing</td>
<td>• Pre-existing conditions</td>
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<tr>
<td></td>
<td>• Documentation</td>
<td>• Experimental procedure</td>
<td>conditions</td>
<td>• Timely filing</td>
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<tr>
<td></td>
<td></td>
<td>• Documentation</td>
<td></td>
<td>• Coordination of benefits</td>
</tr>
</tbody>
</table>
Write-off review does not answer the important operational questions.

What is your initial denial rate?

<table>
<thead>
<tr>
<th>PAYER</th>
<th>TOTAL VOLUME</th>
<th>DENIAL RATE(PRE-APPEAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DAYS</td>
<td>AMOUNT</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>161</td>
<td>$ 567,619</td>
</tr>
<tr>
<td></td>
<td>303</td>
<td>$ 467,518</td>
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<tr>
<td></td>
<td>232</td>
<td>$ 313,364</td>
</tr>
<tr>
<td></td>
<td>55</td>
<td>$ 289,075</td>
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<tr>
<td></td>
<td>37</td>
<td>$ 71,224</td>
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<td></td>
<td>19</td>
<td>$ 71,044</td>
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<tr>
<td></td>
<td>8</td>
<td>$ 57,701</td>
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<td></td>
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<td>$ 51,334</td>
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<td></td>
<td>5</td>
<td>$ 28,248</td>
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<td></td>
<td>16</td>
<td>$ 23,968</td>
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<tr>
<td></td>
<td>4</td>
<td>$ 14,052</td>
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<td></td>
<td>2</td>
<td>$ 9,480</td>
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<tr>
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<td>4</td>
<td>$ 8,012</td>
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<tr>
<td></td>
<td>3</td>
<td>$ 5,523</td>
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<tr>
<td></td>
<td>4</td>
<td>$ 8,012</td>
</tr>
</tbody>
</table>

TOTAL: 857 $ 1,994,330 2.86% 3.23%

DAYS & AMOUNT
BASELINE: DISCHARGE DATE

PATIENT TYPE(S) INCLUDED: INPATIENT
PAYER(S) EXCLUDED: SELF PAY, CHARITY CARE, MEDICARE, MEDICAID, OTHER - CHARITY CARE, OTHER - SELF PAY
Write-off review does not answer the important operational questions

What is your rate of appeal?

<table>
<thead>
<tr>
<th>Denials Appealed</th>
<th>Not Resolved</th>
<th>Outstanding</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,708</td>
<td>$73,814,392</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Write-off review does not answer the important operational questions

How effective are you?

<table>
<thead>
<tr>
<th>Denials Appealed</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Resolved</td>
<td>34,000</td>
<td>$153,728,988</td>
<td>40,980</td>
<td>$154,432,689</td>
<td>61,722</td>
<td>$224,322,026</td>
</tr>
<tr>
<td>Resolved</td>
<td>20,202</td>
<td>$38,752,971</td>
<td>23,886</td>
<td>$28,515,652</td>
<td>22,875</td>
<td>$31,631,706</td>
</tr>
<tr>
<td>Not Resolved</td>
<td>512</td>
<td>$68,948</td>
<td>450</td>
<td>$1,470,733</td>
<td>4,833</td>
<td>$11,102,633</td>
</tr>
<tr>
<td>Resolved</td>
<td>9,221</td>
<td>$75,542,404</td>
<td>11,051</td>
<td>$69,975,342</td>
<td>15,626</td>
<td>$94,532,245</td>
</tr>
<tr>
<td>Not Resolved</td>
<td>4,405</td>
<td>$39,005,137</td>
<td>5,574</td>
<td>$54,307,574</td>
<td>9,330</td>
<td>$60,409,523</td>
</tr>
<tr>
<td>Resolved</td>
<td>23,173</td>
<td>$13,708</td>
<td>$73,814,392</td>
<td>43,286</td>
<td>$288,633,288</td>
<td>23,173</td>
</tr>
<tr>
<td>Grand Total</td>
<td>13,708</td>
<td>$73,814,392</td>
<td>43,286</td>
<td>$288,633,288</td>
<td></td>
<td></td>
</tr>
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Write-off review does not answer the important operational questions. How effective are you?
Write-off review does not answer the important operational questions

What is your cost to recover?
### Market forces contributing to denials

<table>
<thead>
<tr>
<th>Disparate Systems</th>
<th>Inefficiencies</th>
<th>Decrease Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mergers or new system implementations like EHR upgrades, require data to be merged from disparate systems to one centralized system.</td>
<td>The AMA estimates claims processing inefficiencies cost between $21B and $210B</td>
<td>Health systems must find new ways to decrease costs, as private payors and employers can no longer absorb shifted costs.</td>
</tr>
<tr>
<td><strong>System Backlogged</strong></td>
<td><strong>High Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>A common result is that A/R systems to become backlogged.</td>
<td>State insurance marketplaces and high deductible health plans created additional variation and complexity in insurance plans.</td>
<td>Strategies includes lowering cost to collect and bad debt write offs, and increasing cash collections.</td>
</tr>
</tbody>
</table>

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1. [AMA estimates claims processing inefficiencies cost](#).
2. [System Backlogged](#).
3. [High Deductibles](#).
4. [Decrease Costs](#).
Common client problems contributing to denials

No visibility into root cause

RESULTS IN
Increase in total, as well as false or misidentified, denials

Disparate systems and processes

RESULTS IN
Increased cost to collect, time to resolution, write-offs

Inadequate support for process improvement

Denials avoidance requires upstream change, across the revenue cycle
No visibility into root cause

• Denials unaddressable without understanding of root cause
• Managers and analysts are not equipped with actionable data
• Central analytics team takes days or weeks to return reports
• Organizations struggle to pinpoint bottlenecks

Resulting Business Issues
✓ Limited access to up-to-date performance metrics
✓ Inability to diagnose performance bottlenecks
✓ Increased time to denial resolution
Initial denials present reporting challenges

N64 – claim information is inconsistent with pre-certified/authorized services

No authorization?
Review root cause and address scheduling and access?

Bunding?
Service is not separately reimbursable, review for possible billing edit?

Service outside of authorization?
Review with treatment team to identify whether additional services were performed and why?

Not a denial?
Notification from payor about known reimbursement policy?
Disparate systems and processes

Typical Disparate Denials Technology

- **PATIENT ACCOUNTING**: Account Information
- **DENIALS MANAGEMENT**: Denials Worklist
- **CONTRACT MANAGEMENT**: Underpay Worklist
- **SELF PAY MANAGEMENT**: Patient Collection

**Resulting Business Issues**
- Increasing AR days
- Write-offs to bad debt
- Lost revenue

- Multiple disjointed IT Systems
- Inability to accurately identify denial root cause
- Inefficiencies routing accounts to the appropriate team
Inadequate support for necessary process improvement

- Denials avoidance requires significant effort across the revenue cycle. While two-thirds of denials are recoverable, 90% of denials are preventable.

- Without sustainable process improvement, technology and analytics alone will only provide a fraction of the possible results hospitals can achieve.

Resulting Business Issues
- Short-term results only
- Repeated denials without addressing underlying root cause
- Denials incidence remains unchanged
Charge audit and denials prevention
A key to revenue integrity

Revenue Integrity
Program to recognize the full value of every patient encounter

REAL IMPACT: Turn data into information, apply to improvement initiatives

Full-service revenue integrity
Input for contracting

- Processes
- Policies
- Practices
- Staffing
- Contract content

CDM review
Charge capture and audit
Coding and coding audit
Denial Prevention
Patient status