THE ROLE OF DENIAL MANAGEMENT
LOOKING FORWARD TO A VALUE BASED REIMBURSEMENT

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PREMIER MEDICAL APPEALS
Agenda

- INTRODUCTION
- 2017: A YEAR IN REVIEW AND WHAT HAVE WE LEARNED
- CHALLENGES IN TODAY’S MARKET
- DENIAL MANAGEMENT IN TRANSITIONING TO THE VALUE BASED PURCHASING
- DENIAL TYPES AND THE FOCUS FOR 2018
2017 : A Year of Difficult Navigation
2017 to 2018: What Lies Ahead?

- Changes to the ACA will probably impact the number of individuals with health insurance and ended cost-sharing reductions.
- Per OPPS final rule, payment cuts to 1,979, decrease of 0.3% for not for profit, increasing payments to 1,293 for profit by 2.7%. Teaching hospital 1.1% decrease.
- Mergers and acquisitions: the likes we have not experienced
  - Aetna by CVS, DaVita and Med Express by UHC
  - Ascension Health and Providence St. Joseph Health potential
  - Humana and Kindred
  - Amazon and Whole Foods (WF to become pharmaceutical outlets)
- Natural Disasters (Houston and Puerto Rico)
- Cyber threats
- Increase in Telemedicine
- New payer = the patient = increase in bad debt
- Identification and Management of your patient population
- Transitioning to value based payments (APMs, population based)

CFO Challenges in Today’s Market

- Decreasing profit margins
  - Volume leakage
  - Point-of-Service collection
  - Clinical documentation quality
  - Competing reimbursement models
  - Governmental regulations
  - Denials
- Patient Safety and Quality
- Technology
- Managing risk-based health care delivery
- Mergers/acquisitions/affiliations
- Shifting Revenue Mix

Health Care System Disruptors

- Medicare Access and CHIP Reauthorization Act
- Transformative law
  - Transition from: fee-for-service payment model
  - Transition to: risk-bearing, coordinated model
- Bundled payments
  - Fastest Growing payment model within health plans
  - Bundled Payments for Care Improvement Advanced
- Partnerships like CVS
- Natural Disasters (Houston and Puerto Rico)
- Increasing Enrollment in Medicare Advantage Plans
- Narrowing networks or tiered networks

https://www.healthcatalyst.com/top-healthcare-trends-challenges
Current Trends Affecting Profitability

Medicare Access and CHIP Reauthorization Act

Transformative law
  Transition from: fee-for-service payment model
  Transition to: risk-bearing, coordinated model

Bundled payments (BPCI, CPC+)

Cancelled the episodic cardiac and surgical hip/femur fracture bundle payments and cardiac rehab incentive payment models

CJR (comprehensive joint replacement) will remain mandatory in 34 select areas but decrease in scope

AHA News November 2017
Jamaneuraology.com October 2016 Volume 73 No.10. pg 1173.
MACRA Implications

- CMS - increased scrutiny to decrease costs
  - (Provide good care at the lowest cost possible)
- Hospital Provider - increased need for analytics
  - Appropriate utilization of hospital resources
  - Minimize readmissions
  - Properly allocate costs
- Physician Provider – incurring penalties (1%) for failure to implement Electronic Health Records (257,000) and 40% of physicians are now employed by hospitals

HEALTHCARE TODAY

Straddling Fee for service and Value based reimbursement
Why Denials Matter

- Denials can result in a loss of net revenue, often as much as 3%
- Disrupting your cash flow and operations
- Approximately 67% of all denials are appealable
- 90% are preventable
DENIALS ARE COSTLY

- One out of every five medical claims has to be reworked or appealed.
- Approximate rework cost = $25 per claim*
- Hospitals only appeal 48% of all denials
- Appeal rates vary based upon the expertise utilized to perform
- National average is 50%
- 70% overturn rate for RAC claims on average for hospitals
- Write-offs range from 1-5% of net patient revenue
- 1% can mean 2 to 3 million dollar a year for an average 300 bed hospital**

**“4 ways healthcare can reduce claims denials<’ by Kelly Gooch, Becker’s Hospital CFO, July 26, 2016
Definition of a Denial

- Any situation where a payment is less than the amount that was contractually agreed for the services rendered

- The refusal of a payer to honor a request by an individual or the representing provider to pay for a health care service obtained from a health care professional
Specific Denial Definitions

- Soft denial – A temporary or interim denial that has the potential to be paid if the provider takes corrective action. No appeal required

- Hard Denial – A denial that results in lost or write–off revenue

- Preventable or Avoidable – A hard denial resulting from action or inaction of the part of provider services

- Clinical Denial – denial of payment due to medical necessity

- Technical or Administrative – A denial in which the pay has notified the provider by way of remittance advice with specific information describing why the claim or specific item was denied
Denial Types

- REGISTRATION/ ELIGIBILITY/INSURANCE VERIFICATION
- DUPLICATE CLAIMS
- EXPERIMENTAL, INVESTIGATION, NON-COVERED BENEFIT
- INCORRECT CLAIM DATA
- LACK OF MEDICAL RECORDS
- LACK OF AUTHORIZATION
- MEDICAL NECESSITY
- MEDICAL CODING
- LATE FILING
- COB
- BUNDLED SERVICES
Denial Process

Claim Reviewed and Denied
- Technical
- Medical Necessity

Payor Notified with Reason for Denial
- Authorization, Coding, Documentation Eligibility, Late Filing, Routing

Denial Reviewed and Action Taken
- Appeal, Resubmit with additional information, Transfer, Write-off
Denials are Growing

- Gross charges denied by payors amounts to 15% - 20% of the nominal value of all claims submitted
- According to CMS estimates, claim denial rates could skyrocket by 100% to 200% in the early stages of ICD-10 implementation

Payor Denials by Type

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Beds</th>
<th>Annual Billings from Patient Treatment</th>
<th>Estimated Annual Denials Cost @ 15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>185</td>
<td>$63 M</td>
<td>$9.5 M</td>
</tr>
<tr>
<td>Teaching</td>
<td>480</td>
<td>$660 M</td>
<td>$99 M</td>
</tr>
<tr>
<td>Health System</td>
<td>1,100</td>
<td>$2,610 M</td>
<td>$391.5 M</td>
</tr>
</tbody>
</table>

Strategies to Address the Growing Problem

- Understand the basis of the denials
- Calculate your institution’s denial rate
- Assess your team’s remit and outcomes
  - Appeals only, or tasked with case management?
  - Able to respond to all denials?
  - Increasing numbers of write offs?
  - Trend in the turnover rate
- Understand the process
- Know your data and review it quarterly
Denial Management Process

- Cardinal rule of denial management is to address every denial as soon as you get it.
- Track and define denials and keep record of the tracking

  Catalogue denial by type, payor, billed charges and expected reimbursement

Denial Task Force

Interdepartmental meetings -

- Improved timeliness and effectiveness of response
- Integrate technology between clinical and revenue cycle process areas for enhanced communication
- Monitor write-offs
- Monthly meetings with payers

Value of Denials Management Team

- Accelerate the denials management process
  - Many facilities lump all rejected and denied claims into one basket
  - A detailed denial report is essential in determining causation and process problems
- Facilitate improvements being implemented in the Revenue Cycle Management process

Total Claims

- Rejected EDI Claim
- Payor Denied Claim
- Underpayments

Total Claims
STEPS TO DENIAL PREVENTION

- Minimizing denials through an effective concurrent review and notification process
- Recovering as many denied dollars as possible through an aggressive appeals process
- Effectively closing the loop between approval and payment
- Using data to identify key drivers of denials, and developing processes to mitigate these drivers, thereby further reducing denials
Types of Appeals

- **Government**
  - Medicare (RAC, CERT, QIO)
  - Five levels of appeal
    - Redetermination
    - Reconsideration
    - Administrative Law Judge
    - Medicare Appeals Council Review
    - Judicial Review by District Court
- **Medicaid** – usually one appeal level per audit
- **Commercial** - different appeal levels available

www.beckerhospitalreview.com/.../has-it-can-t-eliminate-medicare-appeals-backlog
Value Based Care

To be effective, your organization must know how to easily identify, monitor and engage different groups of patients, including:

- the healthy
- the chronically ill
- the catastrophically ill, and
- especially those patients with emerging or rising risk
CMS FISCAL YEAR 2016 Quality Domains

- 10 percent : Clinical Process of Care
- 25 percent: Patient Experience of Care (HCAHPS Survey)
- 40 percent: Outcomes (hospital mortality measure for acute myocardial infarction, heart failure and pneumonia, central line associated bloodstream infection measure, surgical site infection strata and the AHRQ PSI-90 composite)
- 25 percent: Efficiency (Medicare Spending per Beneficiary measure)

Denials as they impact the quality domains

- REGISTRATION/ ELIGIBILITY/INSURANCE VERIFICATION=HCAPHPS scores
- EXPERIMENTAL, INVESTIGATIONAL, NON-COVERED BENEFITS=HCAPHPS scores
- LACK OF AUTHORIZATION=HCAPHPS scores
- MEDICAL NECESSITY=Readmission Rates,
- LATE FILING =HCAPHPS scores
Denial Management Opportunity

Contracted rates

Denied, rejected, pending with no follow-up

Rework and appeals of above claims

Actual payments

Net revenue after cost of collection

Waymack, Pam, MBA, CHFP, CPHIT. Denial Management, Key Tools and Strategies for Prevention and Recovery.
# Payer Denials per Health Plan

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Aetna (107)</th>
<th>BCBS (39)</th>
<th>UHC (76)</th>
<th>Humana (18)</th>
<th>Cigna (32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care</td>
<td>27.1%</td>
<td>23.1%</td>
<td>14.5%</td>
<td>5.6%</td>
<td>40.6%</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>34.6%</td>
<td>41.0%</td>
<td>67.1%</td>
<td>72.2%</td>
<td>40.6%</td>
</tr>
<tr>
<td>No Authorization</td>
<td>13.1%</td>
<td>12.8%</td>
<td>10.5%</td>
<td>16.7%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Request For Information</td>
<td>6.5%</td>
<td>12.8%</td>
<td>3.9%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Tech/Admin</td>
<td>9.3%</td>
<td>5.1%</td>
<td>2.6%</td>
<td>5.6%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
Overview of Hospital Payments

- Private third-party payors: 49.05%
- Medicare: 29.27%
- Medicaid: 16.08%
- Other government payors: 2.80%
- Other payors: 2.70%
- Unidentified: 0.10%
Distribution of U.S. Healthcare Expenditure from 2014 to 2017 by Payer

In-House versus an Outsourcing Partnership

- **In-house model**
  - Fixed headcount
  - Competing responsibilities
  - Variable number of denials that may impact the ability to appeal 100% of the claims

- **Outsourced model**
  - Avoids fixed headcount costs
  - Valued added staffing that performs as extension of your staff
  - Flexibility to appeal 100% of denials
    - Pay for services needed
    - Quick response time reduces write offs
  - Provides a level of expertise that may not be available internally – potentially higher overturn rate
  - Allows the management team to focus on other areas in the revenue cycle
  - Expertise and Solutions
WHAT TO LOOK FOR IN A VENDOR/ PARTNER

- Overturn rate and how the rate is calculated
- Type of software / IT platform utilized and the extent of security measures in place
- Evidence of adherence to best practices
- Reporting capabilities, including root cause analysis
- Accessibility, flexibility and aligned values
Conclusions

- Implement a Denials Management process
- Review the results of this process monthly to assure VB
- Appeal immediately!
- Educate your team
- Denials Management will still be an ongoing need that may require you to restructure your existing team to meet the needs of your Value Based Reimbursement
Thank you