A Journey in Financial Improvement

Denial Management and the Impact on Financial Stability

April 18, 2018

IDPH Iowa Department of Public Health

Iowa Rural Hospital Learning Opportunity Program

Provided by the Iowa Department of Public Health and HomeTown Health through the HRSA Critical Access Hospital FLEX Grant 2017-2018, Iowa Grant #5888CA04.

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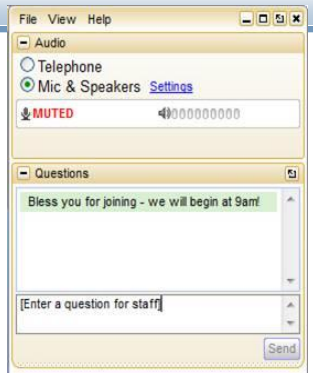
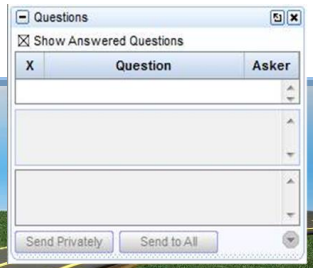
Webinar Etiquette

- All attendees are in "Listen Only" mode
- Questions or comments?
  - Open "Questions" pane in dashboard.
  - Type in comments or questions.
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.





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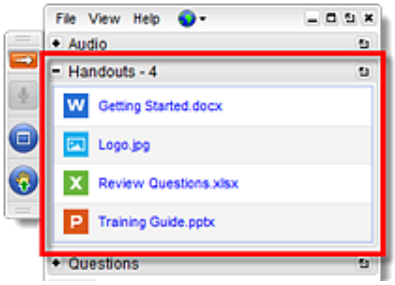
- This webinar will be recorded and emailed to you to share with others on your team.
- Handouts are available for download in the Handouts pane and will be emailed out to attendees after the webinar.



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Iowa Rural Hospital Learning Opportunity Program
Continuing Education

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- American Association of Respiratory Therapy
- American Board of Medical Microbiology
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- American Society for Quality
- American Speech-Language-Hearing Association
- Board of Certified Safety Professionals
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- Clinician's View (Occupational, Speech, and Physical Therapy)
- Federal Emergency Management Agency
- Georgia, Massachusetts and Ohio Board of Nursing
- Georgia Professional Standards Commission
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- National Board for Certification in Occupational Therapy, Inc. (NBCOT)
- National Council for Therapeutic Recreation Certification
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- National Registry of Microbiologists
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Group Participation

Are you on this webinar with a group?

If so, please enter:
first/last names and email addresses
of those in attendance with you in the Questions Pane.

Iowa Rural Hospital Learning Opportunity Program

Agenda

April 18, 2018

Welcome & Introductions	Evelyn Leadbetter
Denial Management and the Impact on Financial Stability	Sandy Sage, RN
Upcoming Events & Resources	Evelyn Leadbetter

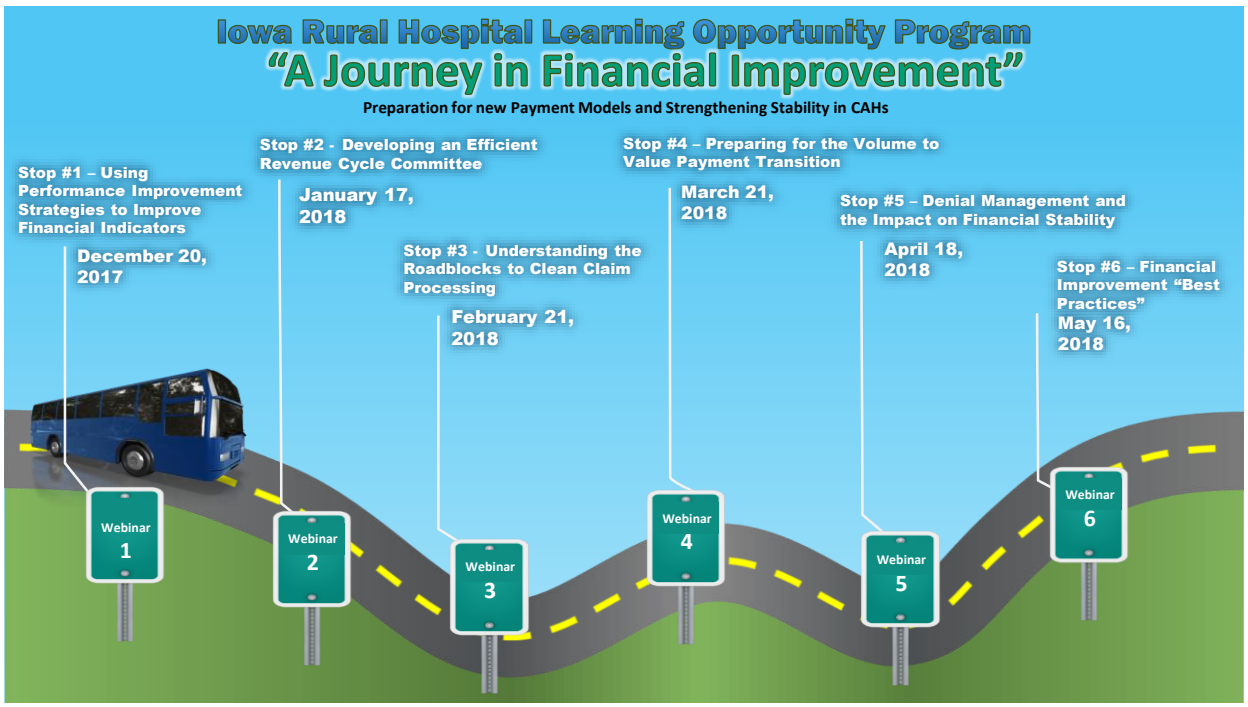
Disclosure of Proprietary Interest

HomeTown Health does not have any proprietary interest in any product, instrument, device, service, or material discussed during this learning event.

The education offered by HomeTown Health in this program is compensated by the HRSA FLEX Grant 2017-2018 Rural Hospital Learning Opportunities Program, Iowa Grant # 5888CA04.

Iowa Rural Hospital Learning Opportunity Program

Program Goals



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Sandy joined the HTHU team in 2009 as an instructor and has developed many of the courses related to the revenue cycle. She has been a Registered Nurse for over 25 years, having begun her career as a clinical manager and in 2000 transitioned to the position of Revenue Cycle Analyst. Sandy has worked as a consultant for rural hospitals helping them with revenue cycle process development and Chargemaster compliance. She became a member of the HTH team in November of 2016. Sandy has been the Team Lead for the Small Hospital Improvement Program in Georgia and Florida and developed the Rev Up Your Revenue Cycle program for our hospitals. Her responsibilities include revenue cycle education, grant implementation and she will be working closely with our hospitals to help them succeed in this complex healthcare environment. A native of California, she moved to Georgia with her family at age 12 and now considers herself a Georgia girl. She has two grown daughters, Amber and Mallory and lives in Cochran, Georgia.

Sandy Sage,
Revenue Analyst

Learning Outcomes

Once you have completed this training, you should be able to:

- Identify the reason to use data analytics to evaluate denials.
- Identify strategies to determine the root cause of denials.
- Describe the importance of contract audits.

Two Things

Healthcare providers want:

1. To provide quality care for their patients and,
2. To get paid for that care.

Barriers to Payment

- Underinsured and uninsured population is rising.
- Urgency to pay is not traditionally assigned to healthcare.
- Patients don't know what they owe.
- DENIALS, DENIALS, DENIALS

Denial Statistics

- Hospitals nationwide lose $262 billion/year in denied claims.
- Payers initially deny approximately 9% of hospital claims.
- You may recover 63% of initial denials after appeals but it costs $118 per claim to appeal and recoup.

Change Healthcare 6/2017

The Cost of Denials

- Denied claims represent unpaid services and lost or delayed revenue.
- They represent increased operating expenses from time spent working denied claims through appeals and administrative tasks.
- They represent decreased productivity in staff hours.

Bottom Line

Denials will erode a hospital's bottom line.

It is TIME!

Use Data Analytics

- Determine the root cause of your denials
- Evaluate what is having the biggest impact on your bottom line
- Is it a Process? Physician? Service line? Payer? Procedure?

What causes denials?

Multiple issues throughout the revenue cycle that can cause a denial to occur.

- **Front end errors in data entry**
- **Missing information or authorization**
- **Invalid insurance information**
- **Medical necessity issues**
- Incorrect coding and charging
- Missing claim attachments
- Incorrect status assignments

Patient Access

Front End Strategies

- Automate eligibility, prior authorization verification to determine if authorizations are needed and if they have been obtained.
- If automation is not feasible, create books/binders with individual payer requirements.
- Provide education for upfront staff. (including monthly Medicare updates and HTHU courses)

Front End Strategies

- Automate contract requirements when possible.
- Manual processes for contract requirements can be created in the form of a matrix with mini-matrixes for each area. (Patient Access, Case management, Business Office)
- Use available medical necessity software.

POLL Question

PA Payer Mini Matrix

	A	B	C	D	E
1					
2	Payer Name	Contracting/Provider Relations Representative (phone, fax, email, physical address to communicate claims issues)	Preauthorization Requirements (inpatient & outpatient)	Eligibility Verification	Medical Necessity
3	Insurance	John Smith	All CT scans	Ph 800-555-1111	Use Medicare rules
4		555-777-8888 phone	All MRI	www.ins.com	
5		888-555-7777 fax	All SDS	Sign in: Hospital	
6			Not on US	PW: County	
7					
8					
9					
10					
11					
12					
13					

Upfront Information

Payer	Plan Name	Contract In Network?	Notes
BCBS	Managed Medicare	Y	
BCBS	State Health	Y	Collect Deductible
Humana	Managed Medicare	Y	
Humana	Wellness	N	Collect OON
Aetna	Choice	Y	Check plan for deductible

Front End Strategies

- Include physicians and their office staff in avoiding upfront errors that cause denials.
- Give them medical necessity cheat sheets for frequently ordered tests.
- Explain to them why you need their help and how it will help their patients.

Middle Strategies

- Include clinical staff in redesigning processes to avoid denials.
- Case Management can lead the medical necessity denial process redesign.
- Look for improvement opportunities in documentation and communication.
- Track clinical denials that do not show up in the business office systems.

CM Mini Matrix

	A	B
2	**Cigna Contract Provisions**	
3	Cigna's payer obligation ends the earliest of the day of discharge noted in the chart or the date specified by Cigna	
4		
5	Hospital to provide Cigna with all information "reasonably requested" to make it's UM decision within the timelines in the request. Hospital should allow Cigna to conduct telphonic concurrent reviews and onsite reviews	
6		
7	If a precertification is obtained Cigna may not contest, request payment or reopen claim except to the extent that Cigna is not liable for payment under Code Section 33-20A-7.1	http://law.justia.com/codes/georgia/2010/title-33/chapter-20a/article-1/33-20a-7-1
8		
9	Records provided at no cost to Cigna for review	
10		
11	Payment will be waived for each day patient is waiting for operating or procedure room space, rescheduling to to no space, inadequate nursing procedure, suboptimal planning, management of medical care or discharge planning issues or failure to obtain diagnostic services.	
12	Above provision to deny pymt will not be enforced if A) the delay is due to the physician not being available and B0 physician is not a radiologist, pathologist or anesthesiologist	

Payers | Notes | **Case Management**

Back End Strategies

- Use data from your Remittance Advices to help you identify claim denial causes.
- Track denials by reason codes.
- Track denials by preventable vs. unavoidable.
- Assign accountability to departments who are the root cause of denials.

CARCs

CARC	Description	Denial Type	Department	Denial Category
1	Deductible Amount	Information	Patient Liability	Patient Liability
2	Coinsurance Amount	Information	Patient Liability	Patient Liability
3	Co-payment Amount	Information	Patient Liability	Patient Liability
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Modifier
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Procedure
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Procedure
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Procedure
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Procedure
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Diagnosis
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Diagnosis
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Diagnosis
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Coding	Diagnosis
13	The date of death precedes the date of service.	Preventable	Billing	Claim Error
14	The date of birth follows the date of service.	Preventable	Billing	Claim Error
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	Preventable	Financial Clearance	Authorization
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Preventable	Billing	Missing Information
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	Information	Duplicate	Duplicate

Helpful Tips

- **Develop a denial management guide with detailed procedures on the following:**
  - How to assign denials to the appropriate denial codes
  - How to appeal by denial type
  - Established adjustments for low dollar denial thresholds
  - Write off approval processes with dollar amounts and management level approvals
  - How to escalate denials to the responsible departments for corrections

Helpful Tips

- Follow Up, Follow Up, Follow Up!
- Appealing a denial does not end the process of denial management.
- Tracking appeals success or failure is key to understanding if your appeals process is working.
- For appeals that fail, evaluate why the appeal failed and find ways to improve the appeals process.

Create Teams

- Assign teams to determine root causes of denials and to evaluate processes involved.
- Breaking down denials into smaller sections will help avoid being overwhelmed by the totality of denials.
- Have the teams report to your revenue cycle committee their progress and recommendations.

Denial Teams

- **Inpatient Medical Necessity** – looks at inpatient denials for medical necessity, downgrades from inpatient to observation, denied days, late submission.
- **Outpatient Medical Necessity** – Looks at issues with medical necessity for outpatient testing or surgeries.
- **Surgery Team** – Addresses inpatient only surgery, status changes pre and post surgery, additional procedures done in OR needing authorization.

Denial Teams

- **Patient Access Team** – Addresses denials that come from missing information, invalid information, authorization issues, payer eligibility issues.
- **Readmission Teams** – Evaluates readmissions that have to be combined or are denied. Evaluates why readmissions are happening and how high risk patients are managed.

Payer Requirements

- Know and monitor payer requirements.
- Each payer has different requirements for claim submissions, deadline dates, medical necessity, timeliness of payments.
- Payers have different contract terms, plan designs, documentation requirements.
- Important to manage each payer successfully to avoid denials.

POLL Question

Contract Compliance

- Monitoring your payments is critical to your financial bottom line.
- Insurance companies must be held accountable for contract compliance.
- Audits must be done to ensure compliance with contract terms.

?????

How can we possibly remember all of the information for all of the different contracts?

Every contract is different.

Different payment methodologies, deadlines, documentation requests, etc.

Develop a Payer Matrix!

Matrix Task Force

Convene a Task Force

- **CFO** should be the leader and champion
- **Include** HIM, Case Management, Accounting, BOM, Revenue Integrity

Matrix Task Force

Responsibilities

- Gather all contracts to ensure all are valid and current
- Identify all service lines in the contract with corresponding rates
- Note special provisions like carve-outs, lesser of clauses
- Make sure all addendums are available i.e. fee schedules
- Define terms and note payer definitions
- Create a matrix template for documentation
- Identify top 5 payers by volume

Key Elements

Matrix should include:

- Payer name and physical address
- Assigned representative and contact information
- Other contact information:
  - General information
  - Provider relations
  - Authorization issues
  - Appeals
  - Medical Director
  - Claims information
  - Benefit verification
  - Emergency care notifications

Key Elements

Matrix should also include:

- Copy of approved insurance cards
- Non-covered services
- List of services requiring authorization
- Time limits for notification of care
- Time limits for authorizations or pre-certifications
- Top billed procedures and expected payment
- Terms of payment
  - Inpatient, outpatient, outliers, carve outs, surgery

Key Elements

Matrix should also include:

- Effective date of the contract
- Date of termination
- Timely filing deadlines

The importance of the date of termination for the contract is vital and there should be a reminder set to notify you at a minimum of **120 days prior** to the termination date.

It can take months to renegotiate a contract so don't wait until the last minute to begin.

PATIENT ACCESS

How should you use the payer matrix?

- **Develop a mini matrix from the master matrix for Patient Access staff**
- Should note who the hospital has contracts with so that if a patient says "Do you take my insurance?" meaning "Are you in network?" they should be able to check quickly to see if their payer is contracted and in network with your hospital.
- What is collectable at time of service.
- What process should be used for eligibility verification and benefits.
- If the payer is not in network, staff should collect up front.

BILLING

How should you use the payer matrix?

- Billing can use the matrix to make sure all claims are billed in a timely manner.
- Monitor for required authorizations.
- Use for rejected claims to determine if procedures were followed for verification, coding, data entry.
- Be able to contact the correct person for claims questions using the contact list.

COLLECTIONS

How should you use the payer matrix?

- Collections should use in coordination with contract management software to evaluate reimbursement.
- Are payments correct?
- Are contractuals correct?
- Are denials valid?

DO NOT TAKE CONTRACTUALS AT FACE VALUE AND WRITE THEM OFF!!!

Matrix Task Force

Continuing Responsibilities

- Review proposed or new contracts and provide feedback related to prior history in renewals and experience with similar contracts.
- Discuss and add to matrix any new payer updates and develop plans for implementing any changes needed.
- Modify contracts if you add any new service lines during contract period
- Identify and track any ongoing payer issues with denials, late payments or other reimbursement issues.

PAYER AUDITS

Audits should be conducted by someone familiar with the terms of the contracts.

- Hospital responsibility to make sure that the payer operates within the terms of the contract.
- Hospital responsibility to identify and recover underpayments.
- Focus on underpayments, denials and internal opportunities for improvement.
- Have a consistent auditing process in place for all contracts.

PAYER AUDITS

- **Compare contract rates with payments.**
- Use your **top 10-20** procedures to determine if those are being paid correctly.
- If underpayments are found **dig deeper**.
- Anytime rates should increase i.e. annual increases, **do an audit** to make sure that the payer has complied.
- **Do not wait** until the accidental discovery or it will be difficult to correct and recover.

PAYER AUDITS

Look closely at denials that reveal trends and patterns.

- Are they for a specific service or diagnosis?
- Are they due to an internal process issue?
- Are they due to payer error?
- Are they due to different interpretations of contract terms?
- Are they avoidable?
- Do you need to meet with the payer representative to discuss the issue?

PAYER AUDITS

- **Do not ignore** what appear to be insignificant underpayments. Small discrepancies can add up to thousands of dollars that negatively affect your bottom line.
- **Be sure** that the error is not caused by the hospital before going to the payer to demand payment.
- If the error is on the hospital side take immediate steps to **correct it**.

Patterns

- **If you find a pattern take these steps:**
  - Take one claim and line item by line item **compare** the paid rate with the contracted rate.
  - Find what lines are being **underpaid**.
  - **Document** clearly. Use contract language if needed.
  - **Contact** the payer and discuss the issues on the claim.
  - Once the payer agrees to pay the claim based on your documentation, you can use that to submit **all other claims** with the same underpayment issue.

Claim Audits

– Make sure when auditing that you include all types of accounts, i.e. inpatient, outpatient, outliers, carve outs etc.

–Work with Case Management to determine if there are issues with upfront processes, i.e. obtaining authorizations, difficulty contacting the payer, receiving return calls etc.

PAYER AUDITS

– **Doing payer audits can be beneficial to**:

- Future contract negotiations
- Reimbursements
- Underpayment recoveries
- In house process improvements
- Denial Management

References and Resources

- http://www.managedresourcesinc.com/2017/09/07/impact-healthcare-reform-hospital-denials-2017/
- http://www.modernhealthcare.com/article/20170627/NEWS/170629905
- https://www.fiercehealthcare.com/finance/4-revenue-cycle-management-challenges

Learning Outcomes

Now that you have completed this training, you should be able to:

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- Identify strategies to determine the root cause of denials.
- Describe the importance of contract audits.

Questions?

Contact Sandy Sage, RN

Sandy.sage@hometownhealthonline.com

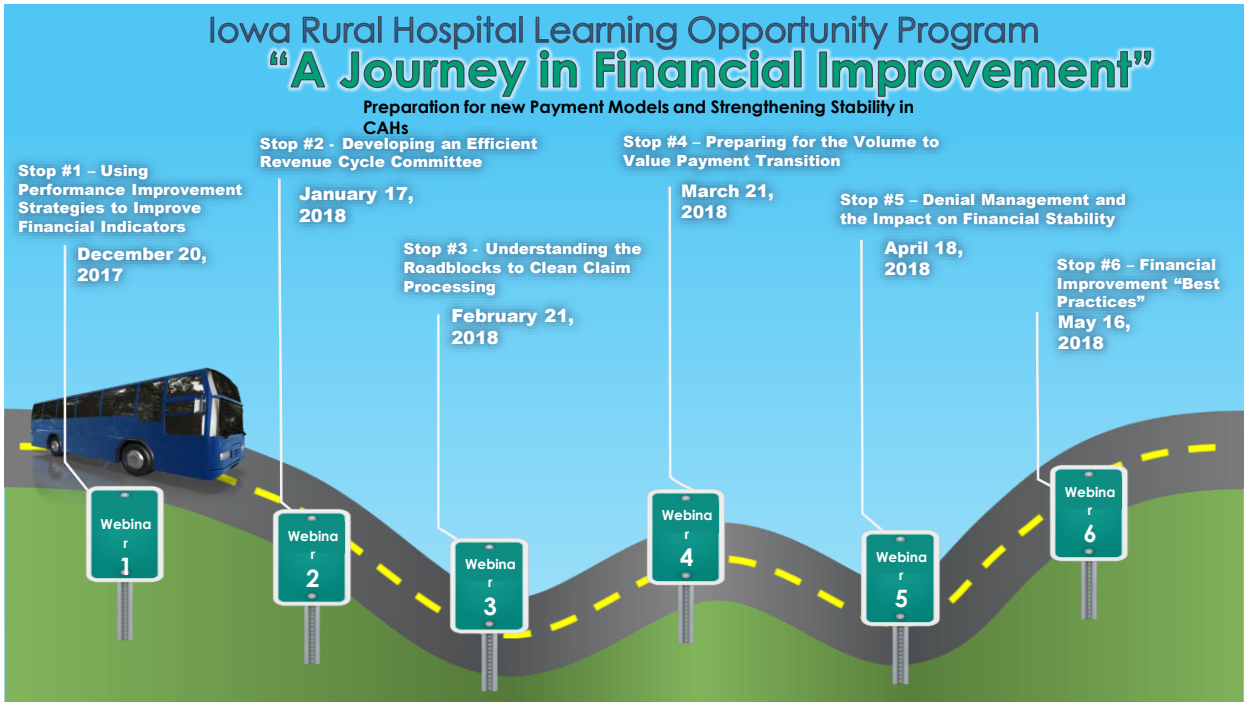
or email

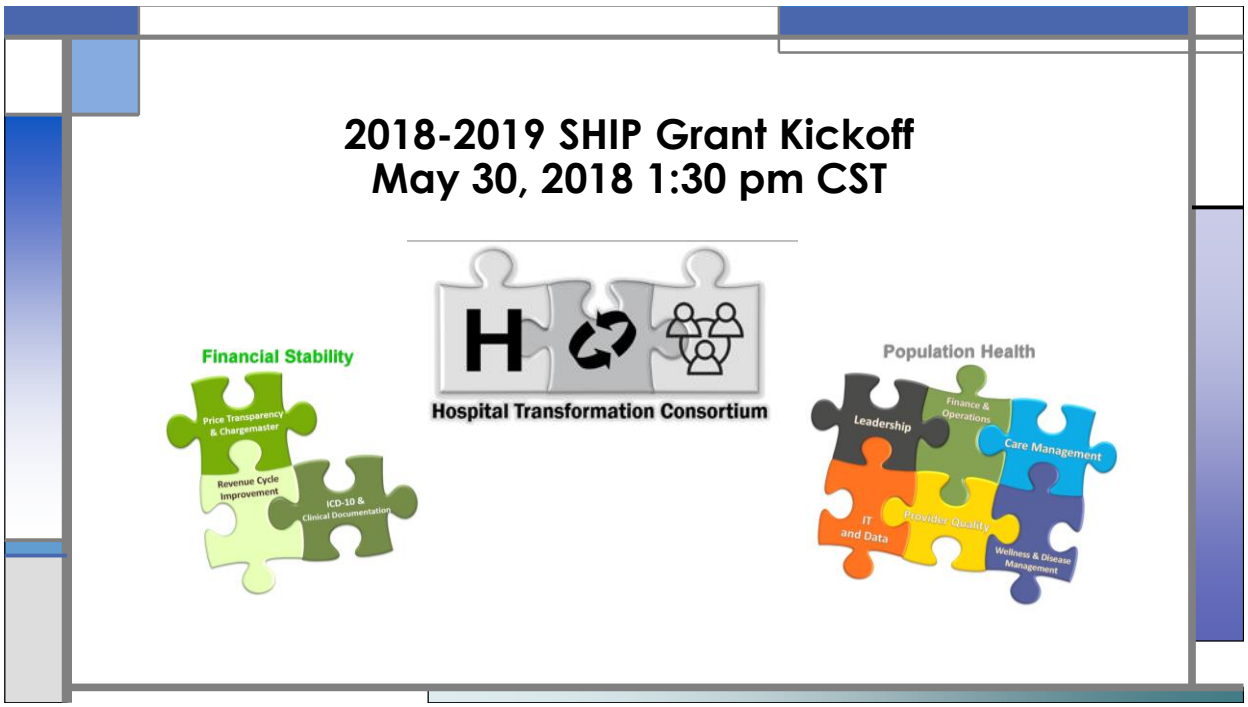
hthtech@hometownhealthonline.com

Iowa Rural Hospital Learning Opportunity Program

Announcements & Upcoming Events

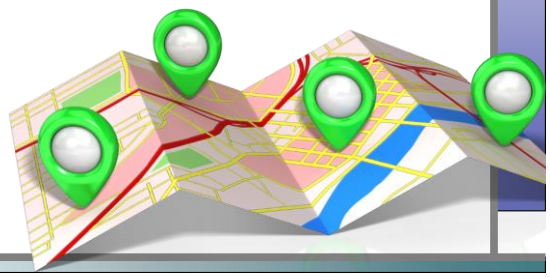
Evelyn Leadbetter, Network Services Manager


Iowa Rural Hospital Learning Opportunity Program
"A Journey in Financial Improvement"
Preparation for new Payment Models and Strengthening Stability in CAHs
Stop #1 – Using Performance Improvement Strategies to Improve Financial Indicators
December 20, 2017
Stop #2 - Developing an Efficient Revenue Cycle Committee
January 17, 2018
Stop #3 - Understanding the Roadblocks to Clean Claim Processing
February 21, 2018
Stop #4 – Preparing for the Volume to Value Payment Transition
March 21, 2018
Stop #5 – Denial Management and the Impact on Financial Stability
April 18, 2018
Stop #6 – Financial Improvement "Best Practices"
May 16, 2018
Webinar 1
Webinar 2
Webinar 3
Webinar 4
Webinar 5
Webinar 6


2018-2019 SHIP Grant Kickoff
May 30, 2018 1:30 pm CST
Financial Stability
Price Transparency & Chargemaster
Revenue Cycle Improvement
ICD-10 & Clinical Documentation
Hospital Transformation Consortium
Population Health
Leadership
Finance & Operations
Care Management
IT and Data
Provider Quality
Wellness & Disease Management

Dashboard & Resources

A recording of today's webinar, handouts & resources, and future webinars dates can be found on the Program Dashboard located at:
www.hthu.net/iowarhlop18



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Tell us how we did!

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