Moving from Denial Management to Denials Prevention

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Denial Trends

• The cost of denials makes up approximately 20% of total revenue cycle expenses.¹

• American Academy of Family Physicians (AAFP) reports the average denial rate ranges from 5-10%.

• Medical Group Management Association (MGMA) found that ‘better performing practices report having 4.05% of claims denied on first submission”.

¹ HFMA Creating a Healthy, Unified Revenue Cycle
Denial Trends

- 2015 to 2017: 47% Increase in Auth/Med Necessity Denials

- 40% of Write-offs: Prior Auth and Medical Necessity Denials

- Eligibility/Demographic: 20-25% of Denials

According to Modern Healthcare, most health systems lose between 3-5% of their net revenue as a result of payment denials.

2. The Advisory Board Company 2015-2017 Hospital Revenue Cycle Benchmark Survey
3. Becker’s Hospital Review “230 Hospital Benchmarks 2017”
Traditional Denials Management

Reactive

Denials received via 835 posted to billing system

Denials worked by Payer Specialists
Denials Prevention

Proactive – Solutions seeking, organizational approach

Effective use of available automation, create edits based on denials for pre-billing intervention

- Map ANSI CARC/RARC codes into issue specific categories with denial origin identified
- Publish and discuss denial reports
- Assign workgroups to specific root causes
- Create targets and celebrate successes
Transform Denial Codes into Actionable Data

- Study Denials by Specialty (Service Line, Institute, Provider)
- Study Denials by Payer and Service Type
- Study Denials by Collectability / Appeal Success Rates
- Study Code to Code Denial Relationships
Geisinger’s Approach

Electronic claims scrubber, rules engine, automated actions

193 custom edits – fired over 169K times in a 6 month period against $119 Million in charges
  – Cost avoidance – no need to resubmit claim, corrected pre-bill

Not enough to look at first pass claim acceptance, the magic is in first pass claim payment
# Cash Posted by Aging Category

## July 2018 Sample – Clinic Provider

| Payer     | 000-030  | 031-060  | 061-090  | 091-120  | 121-150  | 151-180  | 181-270  | 271-365  | > 365    | TOTAL PAYMENTS |
|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------------|----------------|
| Payor 1   | $1,267,356 | $114,211 | $24,288  | $7,893   | $1,510   | $3,772   | $3,427   | 92       | $264     | $(1,422,101)   |
| Payor 2   | $1,306,060 | $1,052,570| $262,020 | $84,159  | $47,898  | $42,310  | $52,494  | $10,520  | $12,082  | $(2,870,112)   |
| Payor 4   | $(2,505,784)| $(206,717)| $(57,660)| $(18,578)| $(18,807)| $(19,805)| $(22,580)| $(470)| $(1,117)| $(2,851,518)|
| Payor 5   | $(6,931,749)| $(553,168)| $(136,494)| $(101,735)| $(43,211)| $(18,908)| $(40,498)| $(39,745)| $(398)| $(7,865,907)|
| Payor 6   | $(1,079,331)| $(726,432)| $(118,092)| $(73,437)| $(39,702)| $(31,984)| $(1,777)| $(9,433)| $7,308| $(2,050,460)|
| Payor 9   | $(18,879)| $(90,722)| $(30,813)| $(16,279)| $(3,829)| $(4,695)| $(7,633)| $(7,772)| $(6,137)| $(186,759)|
| Payor 10  | $(16,722)| $(22,782)| $(41,942)| $(57,731)| $(18,729)| $(822)| $(91)| $205| $(158,361)|
| Payor 11  | $(1,260,184)| $(947,690)| $(656,949)| $(292,020)| $(176,310)| $(121,004)| $(97,930)| $(26,140)| $(19,531)| $(3,597,759)|
| Payor 12  | $(11,207)| $(279,725)| $(75,146)| $(18,716)| $(4,354)| $(3,618)| $(9,698)| $(2,523)| $(15,507)| $(420,495)|
| Totals    | $(39,441,812)| $(8,056,520)| $(1,973,584)| $(902,470)| $(465,624)| $(337,475)| $(321,683)| $(99,290)| $(35,120)| $(51,633,578)|

| % of Cash Receipts within 60 days of DOS | 91.99% |

% of Cash Receipts within 60 days of DOS: 91.99%
Requested edits for process improvements:

CPT 50382 - claims are being billed on 2 lines with RT and LT mods. Needs to come through on 1 line with 50 mod x 1 unit.

CPT 19081/19083/19085 - claims are being billed on 2 lines with RT and LT mods. Needs to come through on 1 line with 50 mod x 1 unit.

Education:

Ophthal – CPT 67028 enter 50 x 1 or 2 units (depending on payer) instead of RT/LT

Ophthal – CPT 67904 notified to use 50 mod x 1 unit instead of E1/E3 mods for Medicare
## Sample Findings – Complex Findings

### Medicare

<table>
<thead>
<tr>
<th>Payor</th>
<th>Count of PYMT</th>
<th>Sum of PYMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE</td>
<td>298</td>
<td>$47,832.64</td>
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</table>

### Medically Unlikely Edits

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### Medical Necessity

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE</td>
<td>155</td>
<td>$52,379.62</td>
</tr>
</tbody>
</table>
Denials Prevention

Establishing a strong denial prevention operation can help minimize revenue loss by increasing the timeliness of payments and lowering the cost of collection.

Increase efficiency by freeing up staff to focus on other tasks.
Identifying Root Causes of Denials

1. Transforming Denial Reason Codes and Data into Action
   • Exploring different strategies to ensure metrics are relevant and easily translated into actionable improvements
   • Categorizing denials (i.e. incorporating more payer/origin specific metrics)
   • Lay a foundation through innovative analysis
   • **Tactical Approach**
     o Effectively translating codes
     o Identifying Denial Origins
     o Monitoring/Analyzing denials by payer
     o Deriving relevant insights from Denial Data
     o Developing Denial Tolerances
     o Disseminating Denial Data
Identifying Root Causes of Denials

2. Incorporating Staff Expertise into an Interdepartmental Denials Governance Structure

- Denial committees and task forces = Key Factor of Success
- Specially designated clinical denial teams resolving potential denials in real time
- **Tactical Approach**
  - Raising Rev Cycle Denial awareness
  - Dedicating impromptu workgroups
  - Building an interdepartmental Denial Management committee
  - Enhancing the Effectiveness of Patient Access Denial committee
  - Aligning Utilization Management
  - Assigning a Clinical Support Leadership role
  - Centralizing a clinical denial efforts into a corporate dept.
  - Deploying coding consultants
Identifying Root Causes of Denials

3. Enacting Targeted Initiatives to Create a Multifaceted Denial Mitigation Strategy
   • Cultivate specific solutions to curb segments of denials
   • Partner with vendors to help achieve denial management goals
   • Tactical Approach
     o Involving frontline staff
     o Standardizing EHR work queues
     o Exploring solutions
     o Supporting medical necessity
     o Fixing registration errors in real time
     o Holding staff accountable
     o Consolidating the insurance master file
     o Improving payer credentialing efficiency
     o Utilizing clinical expertise
     o Holding payers accountable
Teams will continuously diagnose root causes and develop new solutions to achieve regularly updated aspirational targets.

RM/UM leadership set denial target every six months to ensure working teams are continuously striving for improvement.

Working teams identify and prioritize new root causes for denials pain points.

Working teams design and implement novel solutions across the system to address the highest priority root causes.

Set & Track against Targets

Identify Root Causes

Implement Solutions
1. Continued Education and Compliance

- Offer webinars, trainings, and/or meetings for difficult coding areas
- Get input from coding staff
- Team Leaders should accentuate the importance of denials management and develop a clear path to achieving the goal of mitigating denials
- Providers should program into order entry what code/payer combinations require prior authorization
Strategies for Avoiding Denials

2. Stay current on policy updates
   • Visit payer sites to check updates and verify coverage policies
   • Identify payers rules and criteria
   • Understand trends across payers
   • Be able to identify policy updates and implementation dates
   • Providers should review payer contracts for any specific procedures or diagnosis codes to make sure they are appropriately defined
3. Use your tools
   • Ensure edits exist for common codes with local and/or national coverage policies
   • Utilize software program to help track payer rules and ensure claims are compliant
Strategies for Avoiding Denials

4. Track and Trend
   • Monitor any patterns
   • Prioritize and analyze root causes of denials
   • Identify trends and follow up either internally to correct the issue or work with payers to address the reason of denials
   • Quantify and categorize denials
Strategies for Avoiding Denials

5. Communicate
   • Use your trends to educate
   • Create a task force to analyze data, determine the cause, and report progress
   • Communicate within your organization to apply learning and best practices between facilities
Duplicate Denials Leads to Inaccurate Reporting

• It is not uncommon for a claim to be automatically rebilled.
  
  This leads to:
  • Inaccurate billing
  • Extra work on staff
  • Cash recovery opportunities are lost
Accident/Injury - Identifying Appropriate TPL

- It is important to submit the initial claim to the appropriate TPL

  This leads to:
  - Quicker process/payments
  - Decrease in accident/injury denials
  - Decrease in reimbursement
Recoverable Denials Leads to Quick Cash

- 80-90% of three common denials can be overturned which in return can be prevented in the future
  1. Date of Death Precedes Date of Service
  2. Gender Mismatch
  3. Another Payer per Coordination of Benefits
Denials Trending

Geisinger Denials - Avoidable Adjustments

As of December 2016 (Excludes Out)

Net Unadjusted Totals vs. % of Net Patient Service Revenue

Net Adjustments Total Unadjusted vs. Inpatient

Revenue Institute

Net Adjustments Total Inpatient vs. Inpatient

Revenue Institute

* Descriptions indicate if report is adjusted for specific revenue accounts.
Collecting and analyzing data is the backbone of a strong denial management program.

To improve outcomes:
- Create a joint task force that establishes a constant feedback loop between working denials on a transactional basis as well as simultaneously executing the root cause analysis.
- Joint task force should prioritize and establish work queues of issues to be solved on an ongoing basis.
- Joint task force assumes responsibility for educating the rest of the organization on recent issues and solutions.
Sources

Healthcare Business Insights. 2015. Addressing root causes through analytics and a team-based culture. Revenue Cycle Academy.


