

Keys to an Effective Denials Management Strategy

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Presenter Info

- Todd Thomas
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Emdeon
- Eighteen years leading development and delivery of revenue cycle management solutions
- Expertise
 - Claims Processing
 - Denials Management
 - Remittance Processing and Automated Posting
 - Analytics and Business Intelligence

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Keys to an Effective Denials Management Strategy

- What is a Denial?
- Capturing, Qualifying and Measuring Denials
- Managing Denial Followup
- Preventing Denials
- Reporting

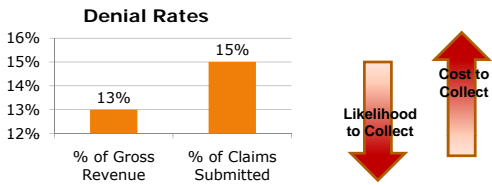
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What is a Denial?

- Generally, a lack of expected payment from a payor
 - Interim or temporary delay in payment
 - Complete Refusal to pay - entire claim or specific lines
- Clinical Denials
 - The payor disputes medical necessity, length of stay, or level of care
 - Usually determined by acuity of illness or intensity of service criteria
 - Can be concurrent or retrospective
- Technical/Administrative Denials
 - Reasons other than Clinical
 - Usually identified in remittance advice using reason codes

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Cost of Denials

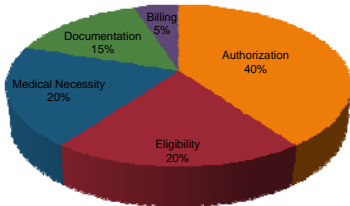


- Nearly 13% of annual revenue is at risk due to payor denials
- Over 15% of claims submitted require additional followup, reducing likelihood of collection, increasing cost to collect, increasing A/R days, etc.

Source: Emdeon 2009

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Types of Denials



- 80% of denials come from patient access
- 90% of denials are preventable
- 70% of denials can be overturned

Source: Emdeon 2009

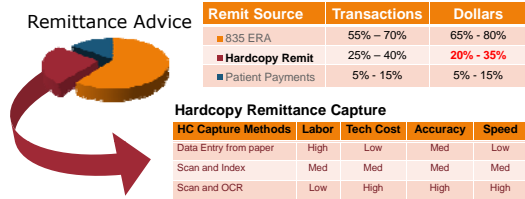
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Capturing Denials

- Sources of Denial Information
 - Remittance Advice (ERA and Paper)
 - Payer Correspondence
 - Claim Status – Accelerated resolution of denials
 - Considerations: availability, quality, fees, reconciliation to ERA
 - Utilization Review, Case Management Logs
 - Expected Payment data (from contract mgmt or HIS)
 - RAC, MIP, other payment integrity programs, etc

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Capturing Denials



- Remittance capture is NOT just a function of cash posting
- ALL adjustment codes and monetary values must be captured
- Don't ignore payers who only provide hard copy remittance advice

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Qualifying Remittance Denials

- What should qualify as a denial?
 - 835 ERA – Remit Status = “4”; usually a zero payment
 - Remit transactions with specific adjustment codes
 - Underpayments – Based on expected payment
 - Other specific conditions

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Measuring Denials

- Define and Assign Denial Categories
 - Assign Reason Codes to a "Denial Category"
 - Prioritize reason codes to identify "primary" reason
 - Enables normalized reporting and workqueue routing
 - Improves quality of categorization for workflow and reporting
- Assign Denial Type
 - Clinical vs. Technical/Administrative
 - Generally determined based on adjustment codes

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Measuring Denials

- Avoid overstating the VALUE of Denials
 - Measure the Collectible Value of Denials
 - Total Charges is NOT the collectible value
 - Denied Charges = Billed – Paid - Adjustments
 - Use Current Account Balance if possible
 - Use Expected Payment if available
 - Measure Initial Denials vs. Subsequent Denials
 - Initial Denials - Count & amount of unique invoices denied
 - Subsequent Denials – the same invoice denied more than once
 - Impacts cost, resolution time, etc

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Managing Denial Followup

- Organizing Your Followup Team
 - Centralized Workflow Model
 - All denials are routed to a central followup team for resolution
 - Distributed Workflow Model
 - Denials are routed to departmental resources for resolution based on denial reason.
 - Organizational variables help determine which model to use
 - Leadership, Staffing Levels, Competence, Available Tools
 - Quality, Security/Access, Timely response, Outcome
 - Behavior – "if they have to fix it, they may stop creating it"

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Managing Denial Followup

- Routing Denials to Work Queues
 - Setup routing criteria that is reasonable and manageable
 - Workqueue should support dynamic prioritization of accounts
 - Highest dollars, oldest, newest, specific error, specific payer, etc
- Define Detailed Followup Procedures
 - Develop written followup procedures for top 10 denial reasons (by count or by \$)
 - Monitor outcomes and tune-up procedures

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Managing Denial Followup

- Documenting Followup Activity
 - Use Standardized Followup Actions
 - Users select from a pre-defined list of actions
 - Improves quality of followup and reporting
 - Use "Canned" Notes
 - Saves time, concise, consistent, professional
 - Minimizes the need to interpret/decipher shorthand
 - Record followup activity in the core billing system
 - Upload notes from denial system- Date, Author, Action, Notes
 - Eliminates duplicate entry
 - Enables everyone to see the followup activity

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Managing Denial Followup

- Appeals Process
 - Define appeals processes by denial reason, by payer
 - Use standard letter templates; efficient, professional, effective
 - Monitor appeal outcomes - If it doesn't work, stop doing it
- Document Root Cause
 - Error Type; Responsible area
 - Who should assign root cause? Followup or post-outcome review
- Document Outcomes
 - Overturned on Appeal; Partial Recovery
 - No Appeal/Write-off, Upheld on Appeal

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Managing Denial Followup

- Automate Followup Actions
 - Minimize the accounts that need to be touched
 - Automated closure of denials zero account balance
 - Automated write-off of low-balance accounts
- Streamline Followup Actions
 - Hide accounts awaiting outcome of a prior followup action
 - Streamline write-off authorization
 - Use appeal letter templates
 - Ability to print and collate Claim, EOB, Appeal Letter, etc.
 - Shortcuts to access the claim, EOB, medical records, payor websites, billing system, etc.

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Managing Denial Followup

- Measuring Followup Performance
 - Recoveries vs. Count of Activities
 - Your most productive resource may not be the one who records the most followup activity
 - Operational Performance
 - Analyze historical followup activity and outcomes
 - Look for opportunities to automate or streamline
 - Stop doing things that don't result in recoveries
 - Financial Performance
 - Measure Recoveries by Resource & Followup Action
 - Measure Recoveries by Payer & Denial Reason

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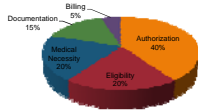
Preventing Denials

- Create a Denial SWAT team
 - Cross functional representation - Patient Access, Case Mgmt/UR, Coding, Medical Records, Billing, Etc
 - SWAT team meets regularly to review denials
 - Assess the denial cause and propose solutions
- Continuous Improvement
 - What problem should you focus on preventing first?
 - The denial reason that creates the most denials (count)
 - The denial reason that holds up the most revenue
 - The denial reason that is hardest to resolve (effort/cost)
 - The denial reason that is easiest to prevent (low hanging)
 - Other criteria (?)

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Preventing Denials

- Eliminating Root Cause
 - Demonstrate - Illustrate, quantify, understand
 - Assess current processes and systems
 - Identify potential solutions
 - Cost-justify changes – cost/benefit analysis
- Typical low-hanging fruit
 - Prior Authorization
 - Eligibility Verification
 - Medical Necessity Screening
 - Claim Validation Rules
 - Internal Procedures (e.g. timely filing)



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Preventing Denials

- HFMA Recommendations for denial prevention
 - Use an outpatient medical necessity system before service
 - Share precertification requirements with physician offices
 - Check eligibility electronically before service (75%)
 - Regular meetings to discuss denial issues with payers
 - Provide physicians with regular feedback on clinical denials

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Best Practice

HFMA recommends these metrics

Denial Management Key Performance Indicators	Target
Overall Denials rate as % of gross revenue <i>2010: Separate measure of Zero pay vs. Partial pay</i>	4% or less
Clinical denials rate as % of gross revenue	5% or less
Technical denials rate as % of gross revenue	3% or less
Rate of collections on underpayments	75% or more
Rate of appeals overturned	40-60%
Total denial reason codes	25 or less

Source: HFMA

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Reporting Tools

- Denial Report Types
 - Denial Status/Inventory
 - Trending and Analysis
 - Followup Analysis
 - Dashboards – measuring performance to goal
- Essential Reporting Capabilities
 - Ability to group, filter and sort by:
 - Facility, Payer Group, Payer, Denial Reason Type, Place of Service, Department, Patient Type, etc
 - Ability to drill down to:
 - CPT, Doctor, Adjustment Code, etc
 - Account level detail

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Reporting Tools

- Operational Performance - Followup Analysis
 - Status by user/team;
 - Days to first Activity, Days to Resolution
 - Productivity – Followup actions, Recoveries, Write-offs, Appeals, Appeals overturned – by user/team
- Financial Performance - Denial Outcomes
 - Recoveries by Payer, Followup Action, Denial Reason
 - Write-offs by Payer, Denial Reason
 - Appeals – % of Denials Appealed; % Overturned vs. Upheld, Recoveries from appeals

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Reporting Tools

- KPI Dashboards – Goal vs. Actual
 - Example Denial KPI
 - Initial Denial Rate
 - Denials as % of Gross Revenue
 - Denial Write-offs vs. Recoveries; Recovery rate (count & amt)
 - Days to First Activity; Days to Recovery
 - Average Denial "Touches" to Resolution (impacts cost & days)
 - Percent of Denials Appealed/Not Appealed;
 - Appeal success rate
 - Use SMART Criteria to define KPI
 - Specific, Measurable, Attainable, Realistic and Timely

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Discussion

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