Delta Region Community Health Systems Development (DRCHSD) Program

Denials Management: Strategies to Reduce Revenue Loss and Re-work Costs

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

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Federal Office of Rural Health Policy

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The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

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National Rural Health Resource Center

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Denials Management: Strategies to Reduce Revenue Loss and Re-work Costs

FEBRUARY 2024

Agenda

Here is what we will cover to achieve our learning objectives

Agenda

Topic	~ Mins.
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Denials Prevention and Management ▪ *Denials Management Strategy* ▪ *Denials Prevention Strategy* ▪ *Denials Case Study Performance Improvement*	35
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Introduction
Meet the Presenters

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Healthcare Performance Improvement

Insurance Denials Impact on Healthcare Providers

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Insurance Denials' Great Impact on Providers

Insurance Denials Have a Large Impact on Organizations' Financials & Patient Experience

Financial Impact

- **3.3%** hospitals' net revenue lost due to claim denials*
- **$4.9M** average hospital annual net revenue lost due to denials**
- **12%** of total hospital claim charges submitted received an initial denial***

Cost of Re-Work

- **$118** average to formally appeal a denied claim*
- **Re-work Costs** including staff & vendor labor (10 to 25% of payments in some cases)
- **Reduced speed to payment** & AR resolution

Patient Experience

- Unexpected **patient liabilities**
- **Delay in patient care** or statements received
- Required patient involvement in **complex appeals process**

*Healthcare Business Insight (HBI) Hospital Financial Benchmarks Q1 2022 National Average**
*Change Healthcare Study 2022***
*Change Healthcare Study 2016****

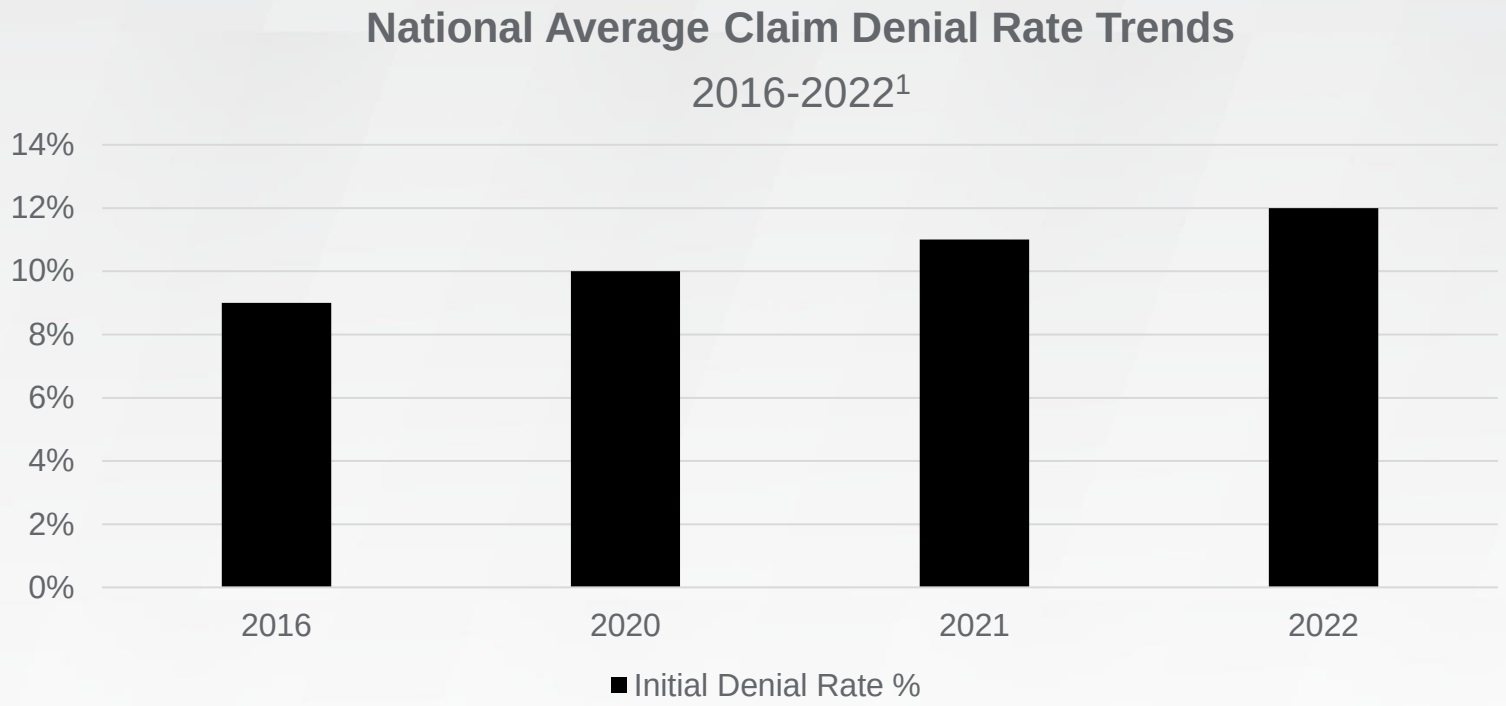
Insurance Denials Are Not Slowing Down

Year over Year Insurance Denials & U.S. Healthcare Complexity Continue to Rise

33% Increase in National Average Insurance Denial Rate from 2016 to 2022[1]

100,000 Estimated number of payor policy changes between 2020-2022[2]

12% of all provider claims submitted are partially or completely denied[1]



[1]2022 revenue cycle denials index Change Healthcare
[2]Experian Healthcare Survey June 2022

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Increased Complexity of Denial Landscape

Health systems continue to struggle with the volume and complexity of denials and information requests as well as successfully defending inappropriate denials

- Hospital median revenue reduction related to MA denials increased 55% (2022-2023)
- Hospitals resources outnumbered against payors (hospital revenue cycle costs typically less than 4% of NR vs. payor 25%+)

Pre-Service

- Concurrent Denial P2P
- Pre-Service OP Denial

Post-Service

- DRG Downgrade
- Paper Correspondence
- Technical Denial
- Clinical Validation Denial
- Coding Denial

Post Payment

- Commercial Audit
- Payor Takeback
- Gov't Audit

American Hospital Association: Medicare Advantage denials jump 56% (beckershospitalreview.com)

Blue Cross Blue Shield of Michigan Mutual Insurance Company and Subsidiaries (bcbsm.com)

Health System Issues with MA Plans & Denials

Medicare Advantage plans deny and delay payment using artificial intelligence and recent increase in regulation discussion and health systems pushing back

- **Several recent class action lawsuits** against UHC and Cigna for artificial intelligence (2023)
- 13 recent instances **health systems dropping MA Plans** (2023)

11. Stillwater (Okla.) Medical Center has ended all in-network contracts with Medicare Advantage plans amid financial challenges at the 117-bed hospital. The hospital said it made the decision after facing rising operating costs and a 22% prior authorization denial rate for Medicare Advantage plans, compared to a 1% denial rate for traditional Medicare.

4. Raleigh, N.C.-based WakeMed went out of network with Humana Medicare Advantage plans in October. According to CBS affiliate *WNCN*, the plan provides coverage to about 175,000 retired state employees. WakeMed cited a claims denial rate that is "3 to 4 times higher" with Humana compared to its other contracted MA plans.

6. Brunswick-based Southeast Georgia Health System will terminate its contract with Centene's WellCare Medicare Advantage plan on Dec. 8. The system said it started negotiations with the carrier after years of "inappropriate payment claims and unreasonable denials."

Beckers Article " Hospitals are dropping Medicare Advantage Plans Left and Right: 13 Updates"

UnitedHealth AI algorithm allegedly led to Medicare Advantage denials, lawsuit claims | Healthcare Finance News

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CMS CY 2024 MA Rule Denial Impact

CY 2024 CMS Advantage Rule intends to increase oversight of Medicare Advantage Plans and may provide some relief to inappropriate denials and excess administrative burden

KEY HIGHLIGHTS

The final rule will:
•Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions don't exist in traditional Medicare;
•Direct MA plans to adhere to the "Two-Midnight-Rule" for coverage of inpatient admissions;
•Limit MA plan ability to apply site of service restrictions not found in traditional Medicare; Require health plan clinicians reviewing prior authorization requests to have expertise in the relevant medical discipline for the service being requested;
•Require prior authorizations to be valid for an entire course of approved treatment and to be valid through a 90-day transition period if an enrollee undergoing treatment switches to a new MA plan;
•Establish additional processes to oversee MA plan utilization management programs including an annual review of policies to ensure consistency with federal rules;
•Strengthen behavioral health network adequacy requirements;
•Tighten MA marketing rules to protect beneficiaries from misleading advertisements and pressure tactics;
•Expand requirements for MA plans to provide culturally and linguistically appropriate services;
•Establish a new Health Equity Index to be incorporated into MA plan Star Ratings beginning in 2027;
•Implement statutory provisions of the Inflation Reduction Act and the Consolidated Appropriations Act of 2021 related to prescription drug affordability and coverage for eligible low-income individuals.
Notably, the final rule did not codify the proposed change to the legal standard for identifying an overpayment, which was of concern to hospitals and health systems.

https://www.aha.org/special-bulletin/2023-04-07-cms-finalizes-cy-2024-medicare-advantage-rule

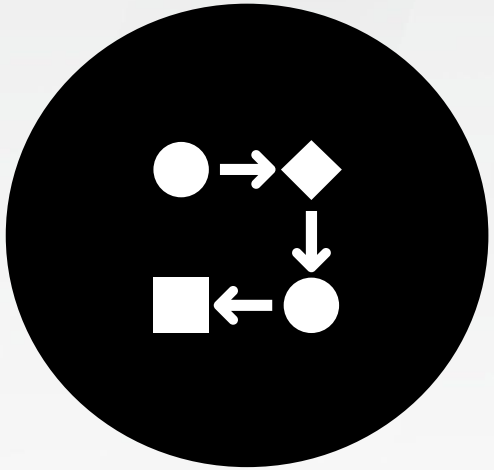
Summarized Rule Changes Impacting Denials

- **Align MA Plans and Traditional Medicare Coverage Guidelines**
  - "Two-midnight-rule"
  - Site of service restrictions
- **Reduce Authorization Burden**
  - Require relevant clinical expertise for payor auth review requests
  - Increase authorization approval timeline
  - 90-day auth transition coverage (switching to new MA plan)
- **Increase CMS Oversight**
  - Annual review of MA utilization management policies

Denials Demand Prevention & Management

Many organizations focus only on short-term management of denials when significant prevention opportunity exists to reduce revenue loss and re-work costs

Current Focus



Denial & AR Management

Improve appeal and accounts receivable workflow management

High Opportunity

Denial Prevention

Preventing denials through improved revenue cycle and integrity efforts

Analytics

Analytics to identify and address root cause issues driving denial trends

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Top Challenges for Rural Healthcare Denials Management

Our clients & healthcare providers at large continue to struggle reducing insurance denials from preventable operational issues and successfully appealing payor denials

1. **Revenue Cycle Staffing –** Staffing & turnover challenges in revenue cycle have limited an organization's ability to proactively approach prevention initiatives & staff education

2. **Denial Visibility & Reporting –** Complex system & reporting limitations and an increasingly complex environment have limited providers' ability to prevent denials & monitor appeals

3. **Technology Adoption –** Many healthcare organizations are significantly behind payor adoption of advanced technology (A.I/Automation) in processing and resolving claims

Experian Health - The State of Claims 2022

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Denials Management

Denials Management Strategy

Denials management requires the right organizational structure, workflows, and technology to successfully appeal and defend payor recoupment efforts

Structure and People

- ✓ Demand based and aligned Staffing
- ✓ Staffing expertise and/or vendors for complex A/R & Appeals
  - Clinical (Physician Advisor)
  - Coding
  - Liability (WC/VA/MVA)
  - Legal
  - *Underpayments/ZBA

Workflows

- ✓ Standard approach to route, monitor, and track denials and unpaid claims across departments
- ✓ Framework to prioritize daily staff denial efforts
- ✓ Standard denials write-off approval and escalation
- ✓ Appeal Templates and Approach

Technology/Analytics

- ✓ Electronic and customized worklists
- ✓ Small balance write-off automation
- ✓ Appeal success productivity and quality reporting
- ✓ Optimized remittance and denial posting

Appeals Management Best Practices

Successfully appealing complex denials requires the appropriate templates, approach and expertise to optimize success

1. **Appeal Templates –** Establish appeal letter templates that include payor required information and present information in a concise format for payors

2. **Appeal Letters –** Appeal claims based on clearly defined state, national regulations and/or payor contractual agreements where possible

3. **Appeal Expertise –** Leverage and route complex clinical or coding appeals to the appropriate person(s) within or outside the organization

Denials Management Workflow and Reporting

Establish a framework and reporting for staff to prioritize denied claim resolution and monitor staff productivity and quality

Denials and Collections Framework

	Monday	Tuesday	Wednesday	Thursday	Friday
Focus	New Unworked Accounts	New Unworked Accounts	Account Worked Balance Open (Past Due)	High Priority Technical Denials	Special Assignments (approaching TF, Credit Balances, Special Worklists, Etc.) *
Priority	Sort High to Low balance	Sort Low to High balance	Sort Oldest to Newest (due date)	Sort Oldest to Newest (date of service)	Sort High to Low balance

Quality Audit Scorecard

KEY: 1=CORRECT 0=INCORRECT Blank=NOT APPLICABLE	Acct#1	Acct#2	Acct#3	Acct#4	Acct#5
Appropriateness of Action Taken					
Was the Action Taken Timely (within due date or framework guidelines)?	1				
Was the appropriate collection action taken?	1				
Was the appropriate action taken to resolve any invoice billing issues?	0				
Was the client escalated to leadership appropriately?					
Completion of Claim Notes					
Was appropriate action code selected and client account noted in Telcor?					
Did the client note correctly document the action(s) taken?					
Was a follow up Due Date assigned? If not, does the note explain why?	1				
Communication (Phone Call)					
Was the call directed at the appropriate client contact?					
Did the call include an appropriate introduction and closing?	1				
Was there an attempt to collect payment?					
Did the call resolve the past due balance or set up an appropriate follow					
Total Score	4	0	0	0	0
Total Points Possible	5	0	0	0	0
ACCOUNT AUDIT SCORE %	80.00%				
AUDIT RESULT	N I				
OVERALL AUDIT %	80.00%				
Great Job or N I (Needs Improvement)	N I				

Productivity Tracker

Meditech Insurance Collections Productivity Tracker						
Staff Name:	Baseline	Benchmark [1]	Target	2/26/2023	2/19/2023	2/12/2023
DLANGLEY	46	285	214	286	115	54
EMONTEE	40	285	214	156	154	186
JSWATTS	73	285	214	80	142	50
KDURHAM	332	285	285	201	192	275
LFALK	89	285	285	103	57	136
NMOODY	-	285	285	74	33	8
SBLEVINS	73	285	214	430	609	637
Total				1,330	1,302	1,346

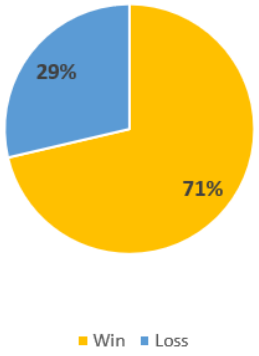
Denials Management Analytics

Develop reporting and procedures to monitor, measure, and provide payor and team feedback on appeal trends

Key Performance Analytics

- ✓ Appeal Timely Deadline Tracking
- ✓ Appeal Overturn Rate by Payor and Denial Type
- ✓ Peer to Peer Completion and Outcome
- ✓ Estimated Net $ At-Risk and Audit Tracking

APPEAL RATES

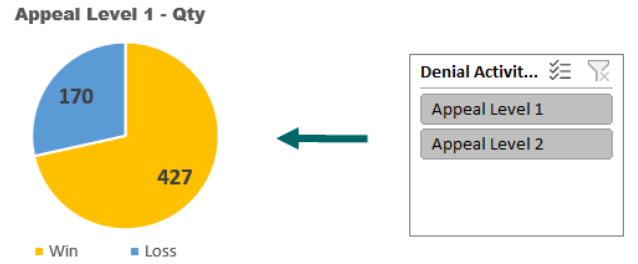


RECOVERED AMOUNT BY MONTH

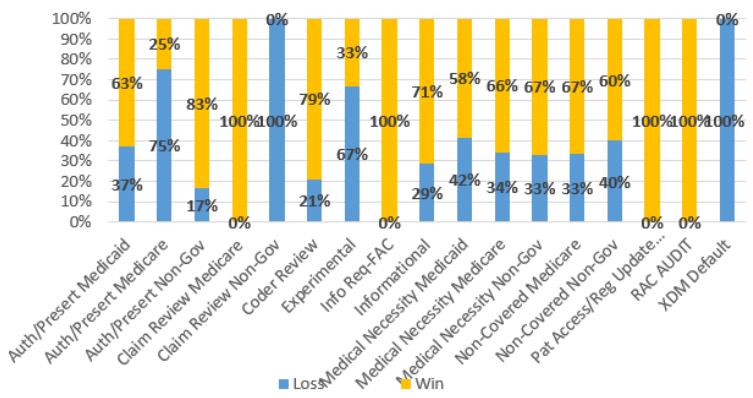
Month	Denied Amnt	Recovered Amnt	%
2018	$ 90,687	$ 5,456	6%
9	$ 17,003	$ 2,422	14%
10	$ 345	$ 52	15%
11	$ 4,021		0%
12	$ 69,318	$ 2,981	4%
2019	$ 4,924,232	$ 355,461	7%
1	$ 75,941	$ 42,996	57%
2	$ 243,261	$ 79	0%
3	$ 290,109	$ 35,189	12%
4	$ 80,628	$ 27,703	34%
5	$ 528,716	$ 156,811	30%
6	$ 453,541	$ 13,782	3%
7	$ 1,981,043	$ 36,607	2%
8	$ 795,640	$ 33,937	4%
9	$ 475,355	$ 8,357	2%
Grand Total	$ 5,014,920	$ 360,916	7%

APPEAL LEVEL TRACKER

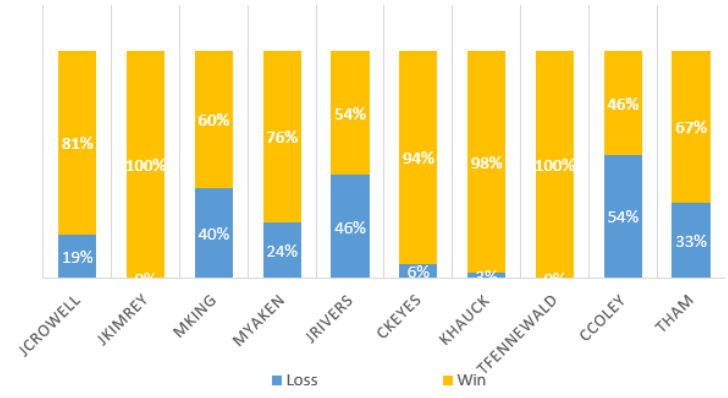
	Appeal Level 1 Qty	Appeal Level 1 %	Appeal Level 2 Qty	Appeal Level 2 %	Total Qty	Total %
Win	427	72%	1	33%	428	71%
Loss	170	28%	2	67%	172	29%
Grand Total	597	100%	3	100%	600	100%



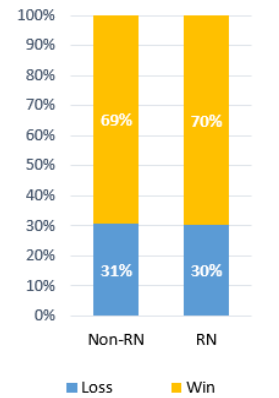
APPEALS BY OWNER GROUP



APPEALS TRACKER BY OWNER



RN VS. Non-RN



Denials Prevention

Denials Prevention Strategy

Effective denials prevention requires continuous process improvement and leading practice revenue cycle operations

Structure and People

- ✓ Revenue Integrity:
  - Denial Prevention Program
  - Payor Contracting
  - Charge Capture
  - CDM/System Maintenance
  - CDI Improvement (IP/OP)
- ✓ Staff Expertise-
  - Data Analysis
  - Performance Improvement and Project Management
  - Training
  - System(s) experience

Workflows

- ✓ Financial Clearance Policy and Requirements
  - Financial Requirements to schedule and perform service
  - Escalation procedures
- ✓ Standard pre-service financial clearance
  - Inpatient Notification and Concurrent
  - Outpatient Pre-Service
  - Financial clearance reporting

Technology/Analytics

- ✓ Real-time verification tools (IP/OP):
  - Eligibility & Benefits
  - Authorization
  - Medical necessity
- ✓ Automated and exception based workflows
- ✓ Analytics:
  - Denial Drill-Down Reporting
  - Real-Time Revenue Cycle Performance Analytics

Denial Prevention Strategy- Assess Opportunity

One of the first steps in reducing denials is understanding where & how much revenue you are losing & the financial opportunity for reduction

Annual Denial Write-Offs by Adjustment Category	Gross Denial Write-Off Total
Authorization	$23,344,000
Medical Necessity	$17,508,000
Timely Filing	$11,672.000
Credentialing	$2,334,400
Late Charges	$1,167,200
Total Gross Annual Denial Write-Offs	**$58,360,000**
Estimated Blended Net Collection Rate	25.8%
Estimated Net Annual Denial Write-Offs	**$15,056,880**
Annual Denial Write-Off Reduction Opportunity	
10% Reduction Net Annual Denial Write-Offs	**$1,505,688**
20% Reduction Net Annual Denial Write-Offs	**$3,011,376**
30% Reduction Net Annual Denial Write-Offs	**$4,517,064**

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Denials Prevention Strategy- Assess Opportunity

Organizations have significant re-work costs in addition to net revenue loss due to insurance denials that are difficult to quantify

Denial Re-Work Cost Reduction Opportunity	Total
Estimated Annual Accounts Requiring Staff Resolution Effort (Accounts Worked) [1]	162,847
Current Average Minutes to Work an Account [2]	11.0
Estimated Average Hourly Staff Rate [3]	$28
Reduced Re-Work Cost Denial Prevention Opportunity Estimation	
30% Reduction in Denials (# of denials)	$250,000
40% Reduction in Denied Account Resolution (# of denials)	$365,000

[1] Example Hospital Insurance Accounts Multiplied by Claim Denial Rate & 2x additional re-work factor
[2] Example Avg. Minutes to work (HBI low range of accounts worked per hour)
[3] Example Estimated blended Avg Hourly Labor Rate (AR team, Specialized Clinic Staff)

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Denial Prevention Program Structure

Establish a Cross-Departmental Denials Prevention Committee Structure and Approach to monitor and pro-actively uncover and address root cause issues driving denials

Hospital Stakeholder Sample Structure	
Executive Sponsors	▪ CFO ▪ Clinical Executive
Committee Lead	▪ Specialized Role—skillset with a strong understanding of overall operational process flow & ability to provide unbiased leadership. Initiative ownership may fit under the revenue integrity department

	Patient Access	Coding/HIM	PFS	Inpatient/UR	Clinic
Project Owner	▪ Director – Patient Access	▪ Director – Coding/HIM	▪ Director – Business Office	▪ Director – Case Management/UR	▪ Clinic Operations Exec Leader
Project Support	▪ Supervisor – Patient Access	▪ Supervisor – Coding/HIM	▪ Supervisor – Business Office	▪ Supervisor – Case Management/UR	▪ Team Lead – Clinic Operations
IT Support	▪ IT Director ▪ Lead Analyst				

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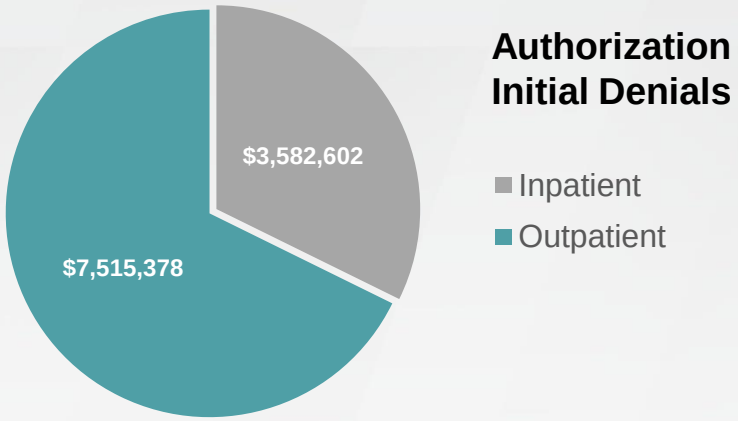
Denial Prevention Program Analytics

Perform a deep-dive analysis across denial reasons, patient type, procedure code, location type, reason category, & procedure category to target performance improvement efforts

Denial/Non-Payment Reason Category	Denied Amount ($)	Denied Amount (#)
Additional Documentation Needed	$32,364,291	39,644
Authorization	$11,097,981	10,504
Eligibility/Registration	$8,922,371	14,132
Coordination of Benefits	$7,633,978	13,444
Miscellaneous	$4,917,687	8,420
All Others	$19,387,811	36,860
Total	**$84,324,119**	**123,004**



Outpatient Authorizations

Denial Reason Category	Denied Amount ($)	Denied Amount (#)
Medication/Infusion	$3,015,951	1,164
Surgical & Other Procedures	$1,334,998	840
Radiology	$798,202	812
Other	$741,199	2,152
Radiation Oncology	$484,131	60
All Others	$1,140,898	2,024
Total	**$7,515,378**	**7,052**

Top 3 Medication/Infusion CPT Codes	Denied Amount ($)
HC-J9201 – Gemcitabine hcl injection	$540,216
HC-J2505 – Injection, pegfilgrastim 6mg	436,174
HC-C9069 – Belantamab mafodontin-blmf	313,202
Total	**$1,289,592**

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Denial Prevention Improvement Opportunities

Develop and execute initiatives targeting reduction of common root cause issues

Denial Reason (Category)	Common Root Cause Issue	Common Improvement Opportunity
Outpatient- Authorization	• **Advanced Imaging Test (CT Scan) order does not match the service authorized by Payor**	• Tech/Radiology Department Order Review prior to service • Order Revision electronic notification & worklist
Outpatient- Authorization	• **Infusion Authorization Not obtained by Ordering Office/Responsible Area**	• Revisions to Financial Clearance Policy • End of Day Missed Auth Report • Post-Service Coding Review (automation)
Outpatient- Medical Necessity	• **Lab test ordered not medically necessary or covered by insurance plan**	• Revise or develop standardized order templates for commonly performed service
Outpatient- Medical Necessity	• **Advanced imaging test not covered based on diagnoses by payor**	• Optimize Pre-service medical necessity screening process and feedback • Screening for medicare advantaged payors

Denial Vendor and Automation Strategy

Technology and Staffing Vendors can improve performance and bridge the gap between payor and provider resources but important to have a comprehensive strategy

Renewed Focus on Automation & Efficiency in RCM

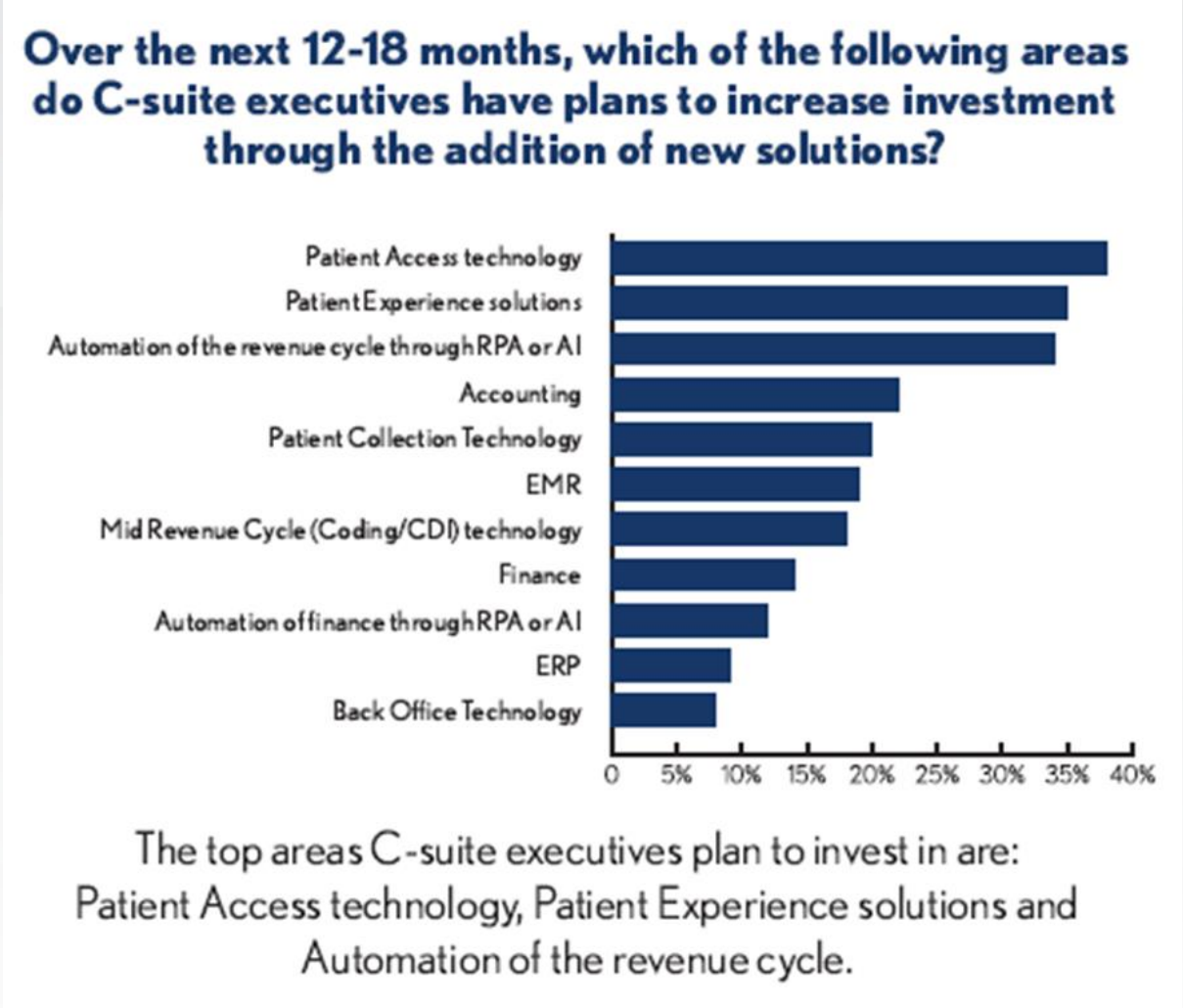
Top automation

& RPA opportunities:

1. Back-end of revenue cycle
2. Patient access
3. Mid-revenue cycle

Strategic Priorities:

1. Prior authorizations
2. Denials & appeals
3. Digital front door



HFMA and Elicitinginsights – Health System Purchase Plans 2023

Denials Improvement Key Takeaways

1. **Appeal Management –** Address denied claims using the appropriate clinical and technical staffing, appeal procedures, and worklists to improve overturn rate

2. **Denials Prevention –** Implement a Denials prevention strategy and focus using analytics instead of only managing current denials to reduce revenue loss and cost

3. **Vendor & Technology Strategy –** Implement and leverage technology and outsourced expertise as needed to keep up with payor advances

Q&A

Questions?

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FORVIS' Denials Management Monitoring Approach

- FORVIS receives an automated feed of the organizational electronic insurance claim response data (835s) & uses a rules engine to turn this information into timely meaningful insights to help support identification of root cause issues driving denials
- Rapid initial installation timeline (average 4 weeks)

Claims – 837 Standard Format

Remit – 835 Standard Format

Streaming Feed of 835s & other data to FORVIS

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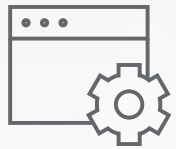
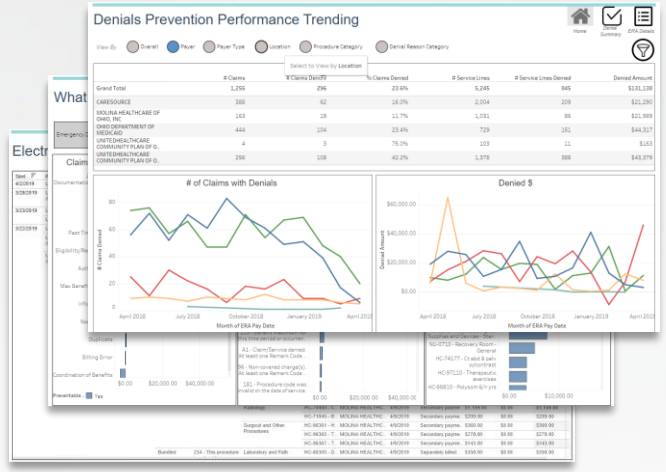
Run through rules engine



Data stored in secure database

Automated refresh of reporting



Meaningful visuals & reporting useful for all levels & areas within organization to prevent claim denials (Operational, Financial, Clinical)

Source: FORVIS Denial Solution Dashboard Demo

FORVIS' Denials Management Monitoring Benefits

Challenges

- Limited denial reporting out of existing EMR's
- Reporting is not categorized to drive action
- Reporting is difficult and time consuming to obtain
- Delays in obtaining reports means information is often outdated by the time it ends (i.e. write-off data)

Denials Management Solution

- Speed to Value
- Real time Actionable Data
- Consolidated data across systems
- Supports all levels of the Organization
- Charge Level Drill-down and Export Capabilities
- Leverage FORVIS Trusted Process Improvement Team

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Val Verde Denial Case Study- FORVIS

Val Verde partnered with FORVIS to help prevent, manage, and drive revenue cycle performance improvement

Cash and Remittance Posting

- Cash and Remittance Posting Automation
- Cash Reconciliation Enhancement

Denial & AR Management

- Re-Design A/R Management and Denial Workflows
- Appeal Templates & Training

Patient Access- Financial Clearance

- Targeted Denial and Patient Liability Training
- Improved Financial Clearance Monitoring

Sustainability & Denial Prevention

- Sustainable Structure for Denials Prevention

Key Financial Success To Date

Denial Mgmt and Posting

- ✓ **19%** improvement in monthly hospital collections
- ✓ **10% increase** in Net Revenue
- ✓ Decreased Medical Necessity Denials

Clinic Operations

- ✓ **37%** increase in monthly clinic collections
- ✓ **Decrease** in unbilled coding days

Val Verde Regional Medical Center

Denials Vendor and Automation Strategy

Establish a Vendor Strategy to select, monitor, and manage outsourced support if needed as they are a significant portion of revenue cycle operations

Denial & AR Vendor	Vendor Description
Billing/Collections	Outsourced Staff Support Billing/Collections Follow Up Staffing Vendor
Denials/AR Management	Software to manage denials, accounts receivables, audits, AR
Contract Management	Software to manage payer contracts and identify payment variances
Zero Balance / Underpayment	Outsourced Staff support to review underpayments and zero balance
Physician Advisory	Outsourced Staff (Physician) to help with in-house denials or clinical review
Clinical Denials	Outsourced Staff Specializing in Complex Appeals and/or Clinical Denials
Legal	Litigation or pre-litigation support for denied claims/underpayments
Analytics*	Staff Productivity, Denial Analytics, Appeal Analytics, Contract Analytics
Insurance Discovery	

Thank You!

Thank You!

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Closing

Questions?

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Questions or Comments

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