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Effective Methods and Tools to Work Denials and Underpayments

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Our Goals for Today

- An overview of Denial Management issues
  - Strategies and tools to prioritize and work Denials
- An overview of Underpayments issues
  - Strategies and tools to effectively use your resources to recover these dollars
- Contracting
  - How to effectively use and communicate with Contracting

I love technology but….

- https://www.youtube.com/watch?v=DYu_bGbZiiQ

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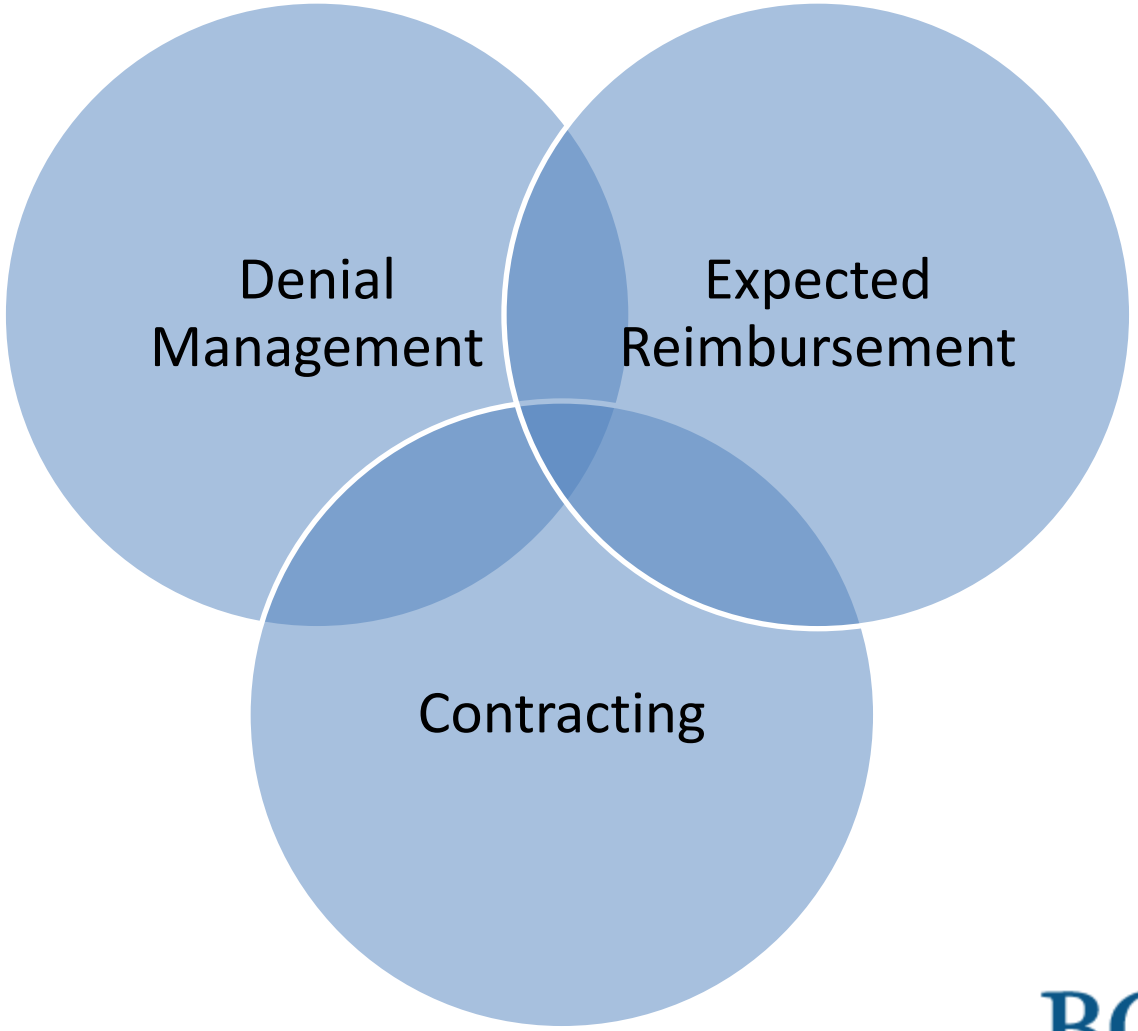
How ACA is Affecting the Revenue Cycle

- The complexities of today's coverage and reimbursement landscape demands a level of focus and expertise unparalleled in the past

Revenue Cycle Imperatives *	Expanded Coverage	Payment Cuts
	Improve Performance and Efficiency	
	Patient Access - Eligibility Processes	Denials Management/ Denials Prevention

* Illustration adapted from hfmap Revenue Cycle Excellence presentation on Reform impacts

A Perfect World



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Denial vs Underpayment

- What is a Denial?
  - Zero paid claim
  - Important to calculate the dollar impact and value claims
- What is an Underpayment?
  - Partial payment
  - Typically the dollar impact is quantified

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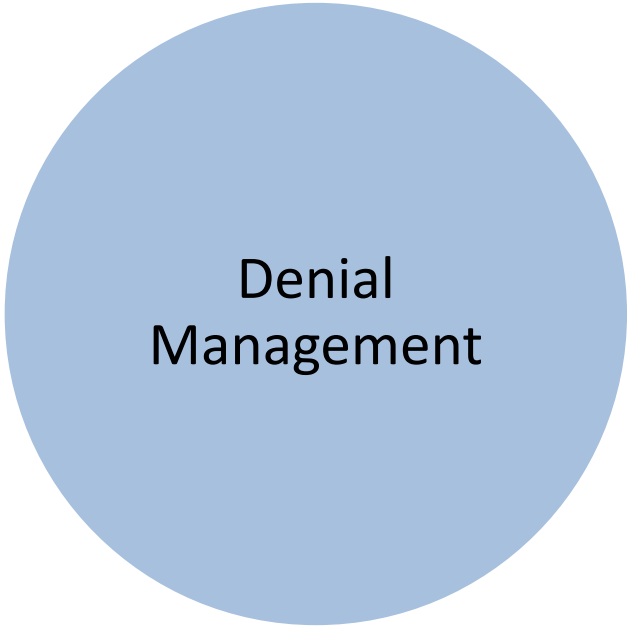
Denial Management - Causes



- Authorization issues
- Medical necessity denials
- Pended claims from payers for additional info
- Clinical documentation
- Incorrect demographic information
- Wrong DRG on bill
- HAC denials
- Third party information
- Legal

Some Keys to Success

- Front end processes to ensure eligibility, notification and authorization
- Ongoing and timely clinical review and communication with payers
- Contract management and IT systems that accurately calculate expected payments
- Denial management team

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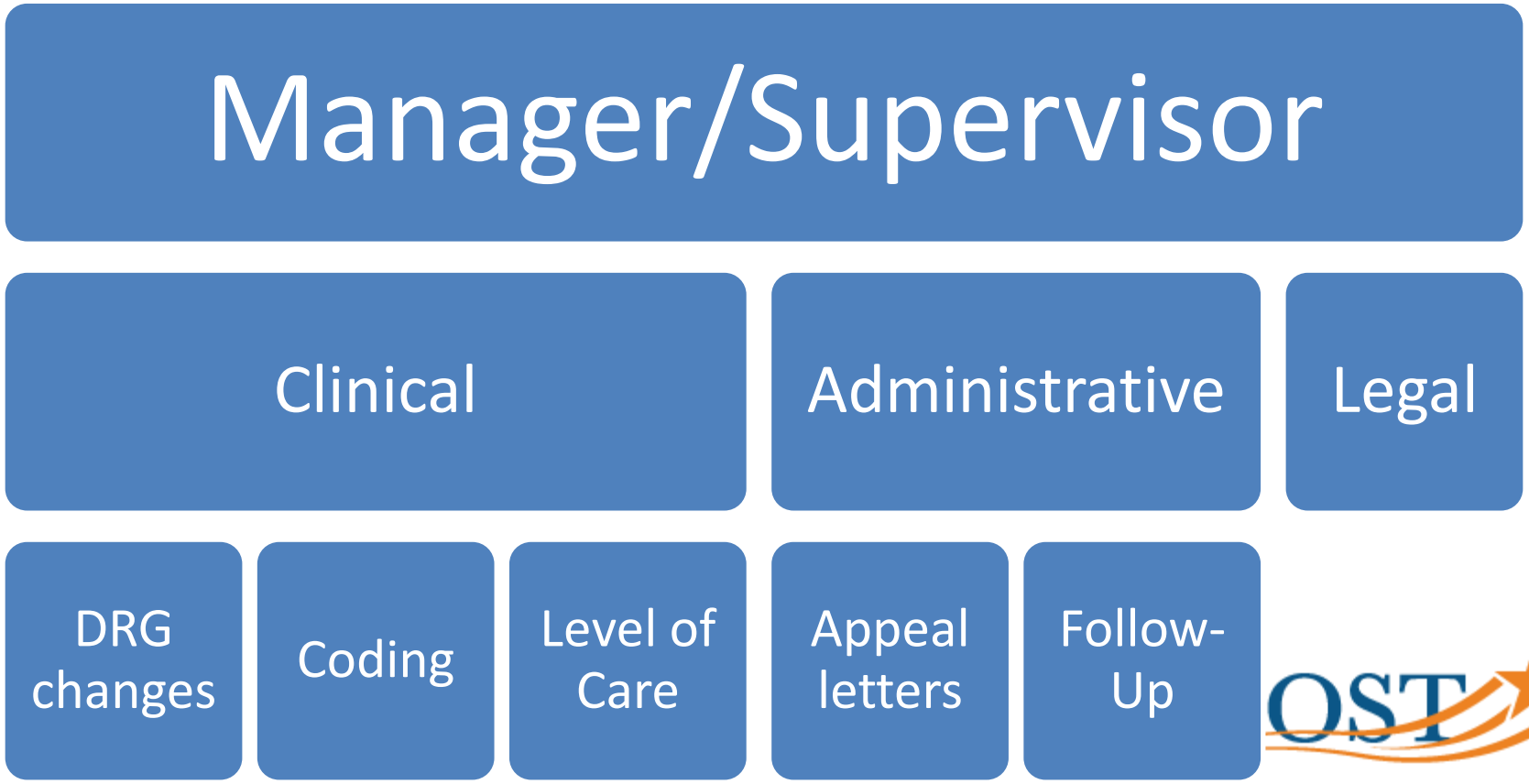
Denial Management Team

- Denial management manager
  - "air traffic controller"



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Denial Management Team

- You don’t need as much clinical staff as you might think
- Strategize by dollar amount and resources

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Identify Trends

- Medicaid system difficulty with hyphenated names
- Sterilization charges
- IP vs Observation
- Sleep Center – Pre-Auth
- Payer issues
  - United process
  - Provider representatives

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Quiz Time – Denial Issue Hierarchy

- Authorization issues
- Medical necessity denials
- Pended claims from payers for additional info
- Incorrect demographic information
- Incorrect DRG on bill

Answer – Denial Issue Hierarchy

1. Incorrect demographic information
   - Very simple, can lower scope to low dollar amounts
2. Incorrect DRG on bill
   - Clinical involvement but minimal, re-drop bill
3. Pended for additional information
   - Stall tactic? Easy enough to send in requested info
4. Authorization
   - Requires reviewing chart notes and writing appeal
5. Medical Necessity
   - Requires reviewing chart notes and writing appeal
   - Possible 2nd level clinical appeal

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Develop a Strategy/Plan

- Use metrics – Payer Analysis

#	Payer	Denied	Paid	% Overturned
1	Molina	$ 2,000,000	$ 500,000	25%
2	Blue Cross	$ 1,000,000	$ 500,000	50%
3	Medicare	$ 700,000	$ 500,000	71%
4	Cigna	$ 500,000	$ 250,000	50%
5	Aetna	$ 500,000	$ 200,000	40%
6	GroupHealth	$ 200,000	$ 100,000	50%
	Totals	**$ 4,900,000**	**$ 2,050,000**	**42%**

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Develop a Strategy/Plan

- Use metrics – Root Cause Analysis

#	Issue	Denied	Paid	% Overturned
1	Authorization	$ 2,000,000	$ 500,000	25%
2	Additional Info	$ 1,000,000	$ 500,000	50%
3	Incorrect Demo	$ 700,000	$ 500,000	71%
4	Incorrect DRG	$ 500,000	$ 250,000	50%
5	Med Necessity	$ 500,000	$ 200,000	40%
6	Coverage	$ 200,000	$ 100,000	50%
	Totals	**$ 4,900,000**	**$ 2,050,000**	**42%**

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HFMA MAP Key

- Denials Overturned by Appeal
  - Purpose: Trending indicator of hospital's success in managing the appeal process
  - Value: Indicates opportunities for payer and provider process improvement and improves cash flow
  - Calculation

$$\frac{\text{Number of appealed claims paid}}{\text{Total number of claims appealed and finalized or closed}}$$

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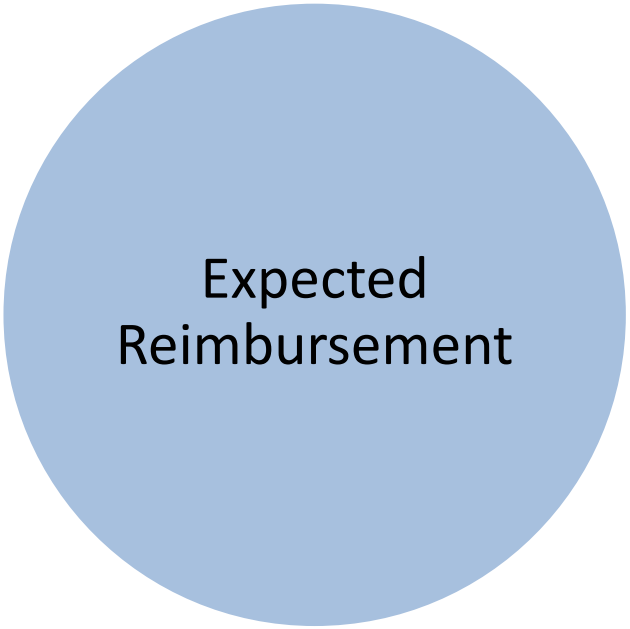
Have a Plan

- High dollar
- Group by payer
- Denial issue hierarchy
- ICD-10
- Evaluate partner opportunities
  - Ensure denials are being worked
- Scheduled meetings

Use Data →Develop Metrics

- Ideally, data from denials should directly feed continuous improvement efforts
- Evaluating payer and root cause analysis can identify opportunities for improvement and education
- Ultimate goal is to prevent future denials

Expected Reimbursement



- Identifying and recovering underpayments
- Ensuring contract management system is updated
- Reporting findings to contracting

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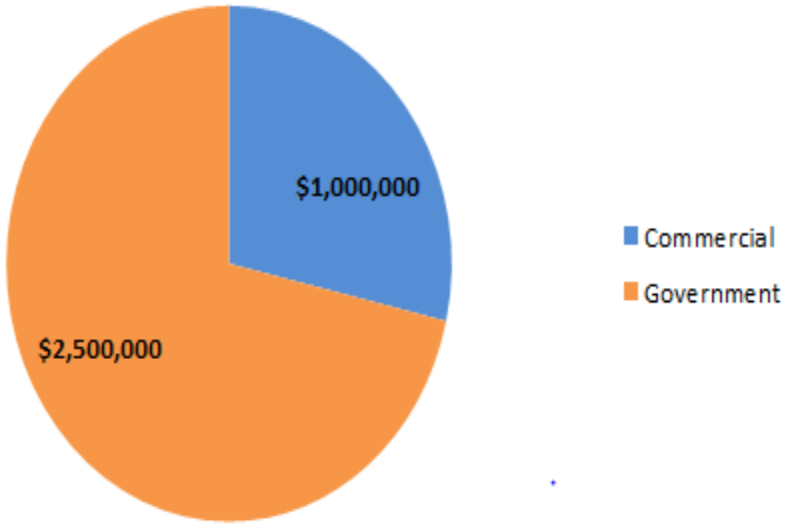
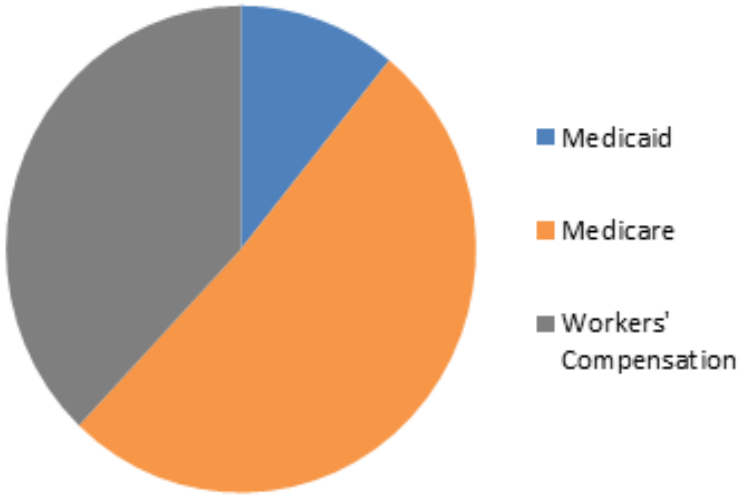
Underpayments Today

- The changing landscape

Payer Type	Accounts	Identified Underpayments	Average Underpayment
Commercial	200	$1,000,000	$5,000
Government	700	$2,500,000	$3,571
Totals	**900**	**$3,500,000**	

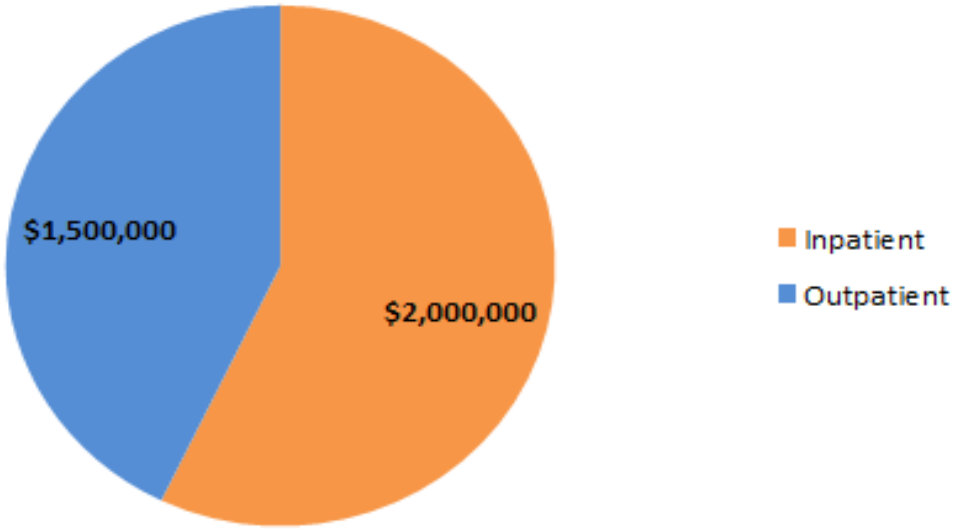




Underpayments Today

- Inpatient and Outpatient Review

Patient Type	Accounts	Identified Underpayment	Average Underpayment
Inpatient	300	$2,000,000	$6,667
Outpatient	600	$1,500,000	$2,500
Totals	**900**	**$3,500,000**	



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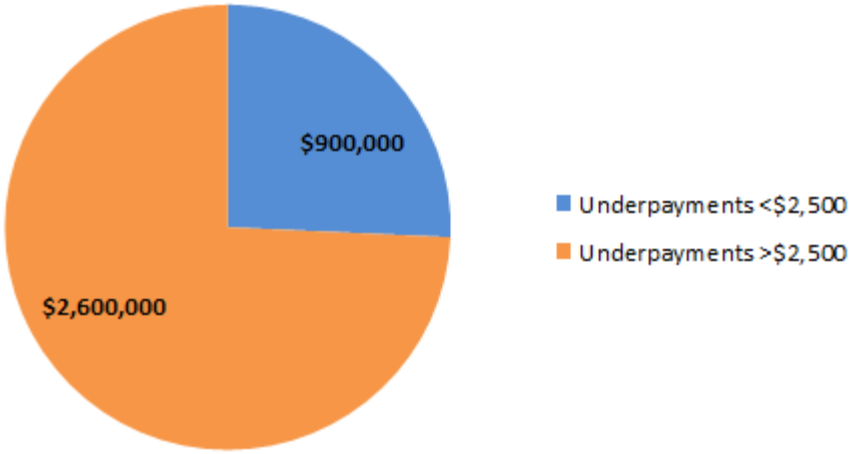
Underpayments Today

- Payment Amount

Payment Amount	Accounts	Identified Underpayment
Underpayments <$2,500	600	$900,000
Underpayments >$2,500	300	$2,600,000
Totals	**900**	**$3,500,000**



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Underpayments Today

- Pop Quiz?!
  - You only have 2 FTEs to work Underpayments how do you prioritize your resources?

Underpayments Today

- Pop Quiz?!
  - You only have 2 FTEs to work Underpayments how do you prioritize your resources?

1. Inpatient
2. Underpayments > $2,500
3. Don’t overlook Government payers
4. Payer/Root Cause Analysis
5. Adjustment time limits

Government Payers

- Medicaid and Managed Medicaid
  - The last on the list for internal teams
  - Culture of “take what you can get”
  - Review denials and auths
  - IP vs OBS
  - Review all payments
  - Review DRG (APR-DRG)

Government Payers

- Medicare
  - All comes down to coding
  - Exempt units (IRF/IPF)
  - Drug dose discrepancies
  - Blood factor drugs
  - Neurostimulator coding/modifiers
  - Transfer payment review
  - Uncompensated Care Payment Add-On
  - Incorrect DRG

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Government Payers

- Medicare Advantage
  - Same as Medicare ++
    - DRG Down coding
    - Organ Acquisition
    - Medicare Sequestration
    - IME

Government Payers

- Workers' Compensation
  - Lots of small dollar underpayments
  - Several payers/adjustors
  - Border hospitals

Small Dollar Underpayments

- Auto
- Work Comp
- Outpatient

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Underpayment Special Projects

- Post Acute Transfer DRG Review
  - Transfer rate only applies to the following discharges status' and one third of DRGs
    - **03** Skilled nursing facility
    - **05** Another type health care institution not defined elsewhere
    - **06** Home health
      - Within 3 days following discharge
    - **62** Inpatient rehabilitation
      - Includes distinct part unit of a hospital
    - **63** Long term care hospitals
    - **65** Psychiatric hospital
      - Includes distinct part unit of a hospital

Underpayment Special Projects

- Coordination of Benefits (COB) Review
- Review contract language
  - Secondary payer reimbursement
  - Often BLB
- Create an audit matrix
- Review claims

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Underpayment Special Projects

- Unique DRG Review
- Review payer contracts and state fee schedules
- Case study of working with Payer Contracting

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Underpayment Special Projects

- Low % reimbursed claims
- Set a scope
  - Charges > $20,000
  - Reimbursement < 5%

Payer Issues

- Bundling and Charge Denials
  - Cigna
  - Aetna
  - Molina
- How to fight these!
  - First steps
  - Review contract language
  - United front with Payer Contracting

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Negotiating Discounts

- International Claims
  - Global Excel
- Correctional Institutions
- Prompt Pay Discount Policy

Charges	Discount	Approval Level
>$100,000	7%	VP, Revenue Cycle
$50,000 - $99,000	5%	Director
<$50,000	3%	Manager

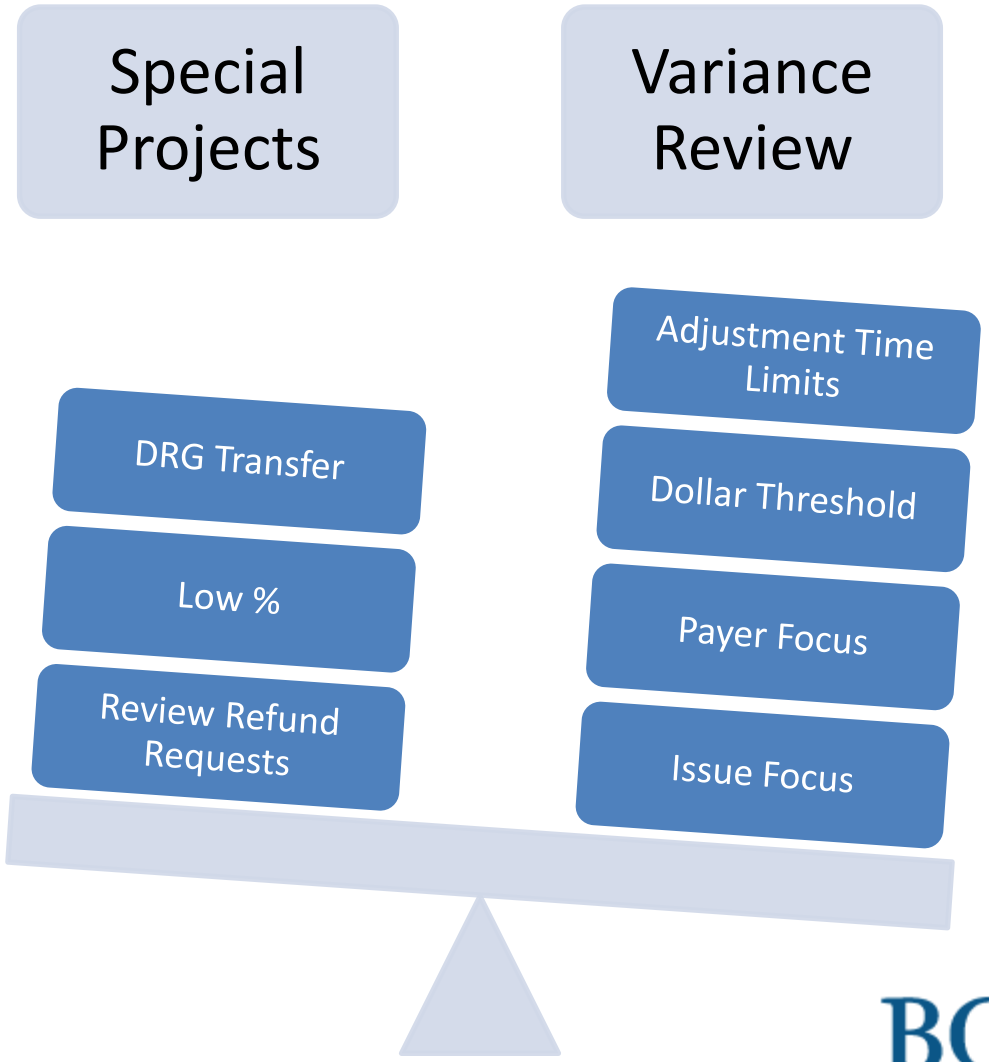
Working with Patient Access

- Financial Class Coding
  - Kaiser
  - Miscellaneous

Updating Contract Management

- Avoid false positives
- Contracts are always being updated
- Fee schedules change regularly
- Don’t forget to load ALL payers

Expected Reimbursement - Work Plan



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Use Data →Develop Metrics

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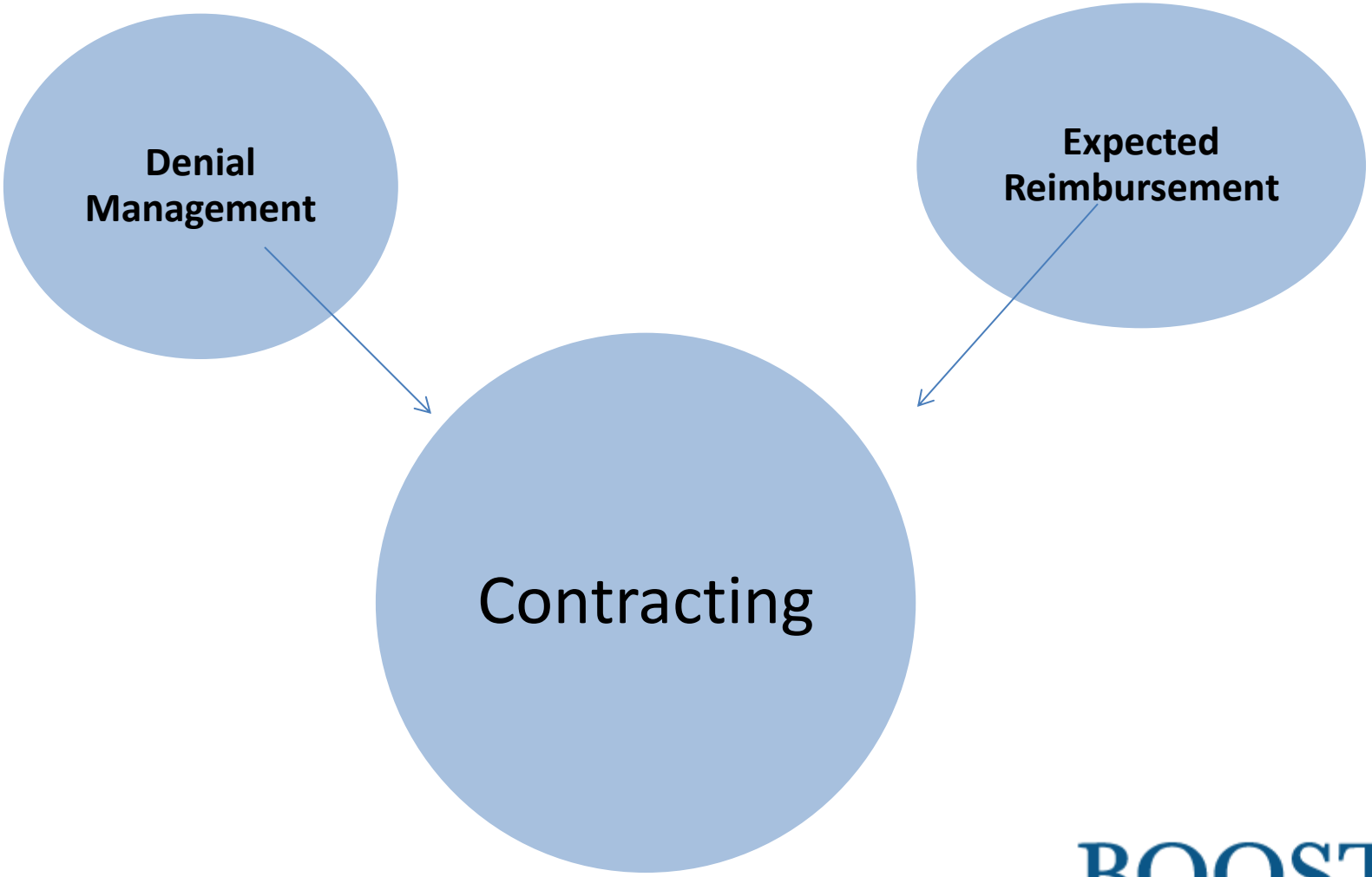
Communication



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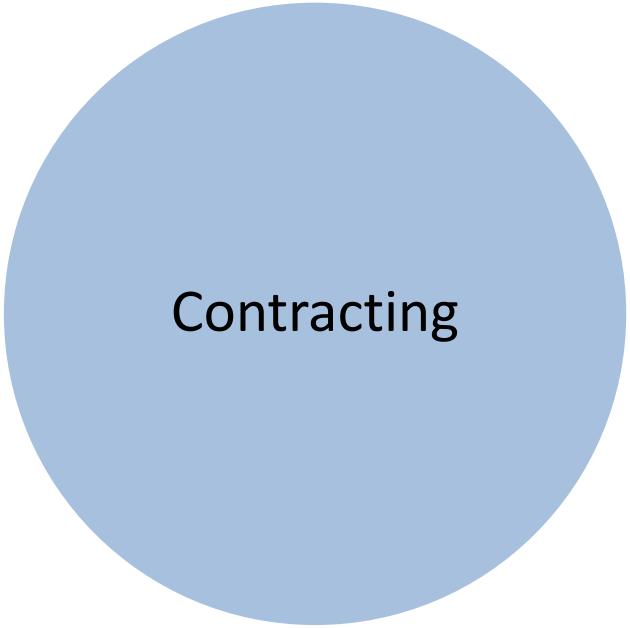
Working with Payer Contracting



- Relationships with payers
- Revenue cycle assistance with negotiation process
- Consistency across all contracts
  - Government v. Commercial

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Payer Contracting

- Consistent regular communication is key!
  - Monthly team meetings
- Involve Revenue Cycle in negotiation process
- Early identification of issues is paramount
  - Mole hill vs. Mountain

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Settlements Criteria

- Settlement Criteria
  - Money involved
  - Claims Frequency
  - Payer Engagement and acceptance of issues
  - Mass denial for Hospital or Payer claims system coding error
  - Preferred for Commercial lines of business
- Goal: Reduce Admin Costs!

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Line by Line Criteria

- Sporadic and disjointed claim denials
- Appeals might be needed
- Patient Specific denials
  - Medical Necessity denials
  - Medical Chart reviews
- Preferred for government lines of business

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How do we bring issues forward?

- Step 1: Monthly meetings
- Step 2: Each issues has an SBAR
  - Situation
  - Background
  - Analysis
  - Recommendation

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How do we bring issues forward?

- Why the SBAR?
- Clean approach to articulate the issue
- Promotes thoughtful analysis
- Saves resources

- Step 3: Contracting communication with the payers

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Tips to communicate with payers

- Be concise use the SBAR
- Provide examples
- Use contract language to support your position
  - Underpayments
  - Clean Claims
  - Denials
  - Joint Operations Committees

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Joint Operations Committees

- Contracting language around Joint Operations Committees
- Useful for payers with high administrative costs
  - Days in AR
  - Medical management issues
  - Discharge to lower level of care
  - Claims denials

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Contracting approach to ICD-10

- Payer risk assessment
  - Goal: Protect cash flows!
  - Risk areas within the hospital
    - PFS and HIM
  - Score payers by:
    - Net allowed payment
    - Current Denial rate
    - Days in AR with ICD-10
    - ICD-10 testing willingness
      - Initial “ping” and End to End testing

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Contracting approach to ICD-10

- Deploy contract language
  - Prompt payment interest penalty
  - Interim payments
  - Prior authorizations
  - End to End testing
  - ICD-9 support and maintenance
    - To align with state language around claims reprocessing

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Contracting trends

- Sequestration
  - Issue: How payers are coding sequester on remits
  - Loaded into the allowable or:
  - Inconsistent usage of RA codes
  - Countermeasure:
    - Increase MA reimbursement
    - Reject the sequester
      - Argument (RESEARCH)

Contracting Trends

- Lesser of language
  - Will pay allowed to billed charge whichever is less
  - With government reimbursement
- Large state employer groups in Oregon legally mandated to pay on CMS methodology (Senate Bill 204)
- CMS methodology with lessor of language
  - Payers want to pay like CMS but only will pay up to billed charges
  - If the billed charges are low, this is an issue
  - If the billed charges are high, not an issue

Contracting Trends

- Standardizing Charge master (CDM) Language
  - Establish an percentage threshold
  - Standardized notification
    - Align to align with fiscal or calendar year
    - Same increase with CAH and DRG's

Contracting trends

- Focus on payers with high administrative costs
  - Look at the internal costs to process claims, denials, underpayments,etc.
  - Time to post RA/EOB's
  - Days in AR
- Admin fee should reflect the cost

Contracting Trends

- Payment Accuracy Provision
  - Collaborate with payers to validate CMS pricing and fee schedules
  - Settlement and true up language
  - Refund Language
    - Claims with variance less than $XX shall not have refunds processed
    - This is a “Win-Win”

Contracting Trends

- Pay for Performance
  - Tips to create standardized P4P programs
  - Use what you are already measuring
    - CMS VBP
    - Readmissions
    - HACs
    - Other quality programs
  - Create Hospital Quality Scorecard
  - Quantification of monies at risk

Thank you for your time!
Questions?

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