# A Holistic Approach to Denial Prevention and Management

# Agenda

Optimizing Technology and Analytics to improve Denial Prevention

Future Technology  Enhancements for continued improvement

# Current State of Denial Management

# Denial Management Strategies

- Source of Data
- Intelligent Workflow
- Enhanced Reporting

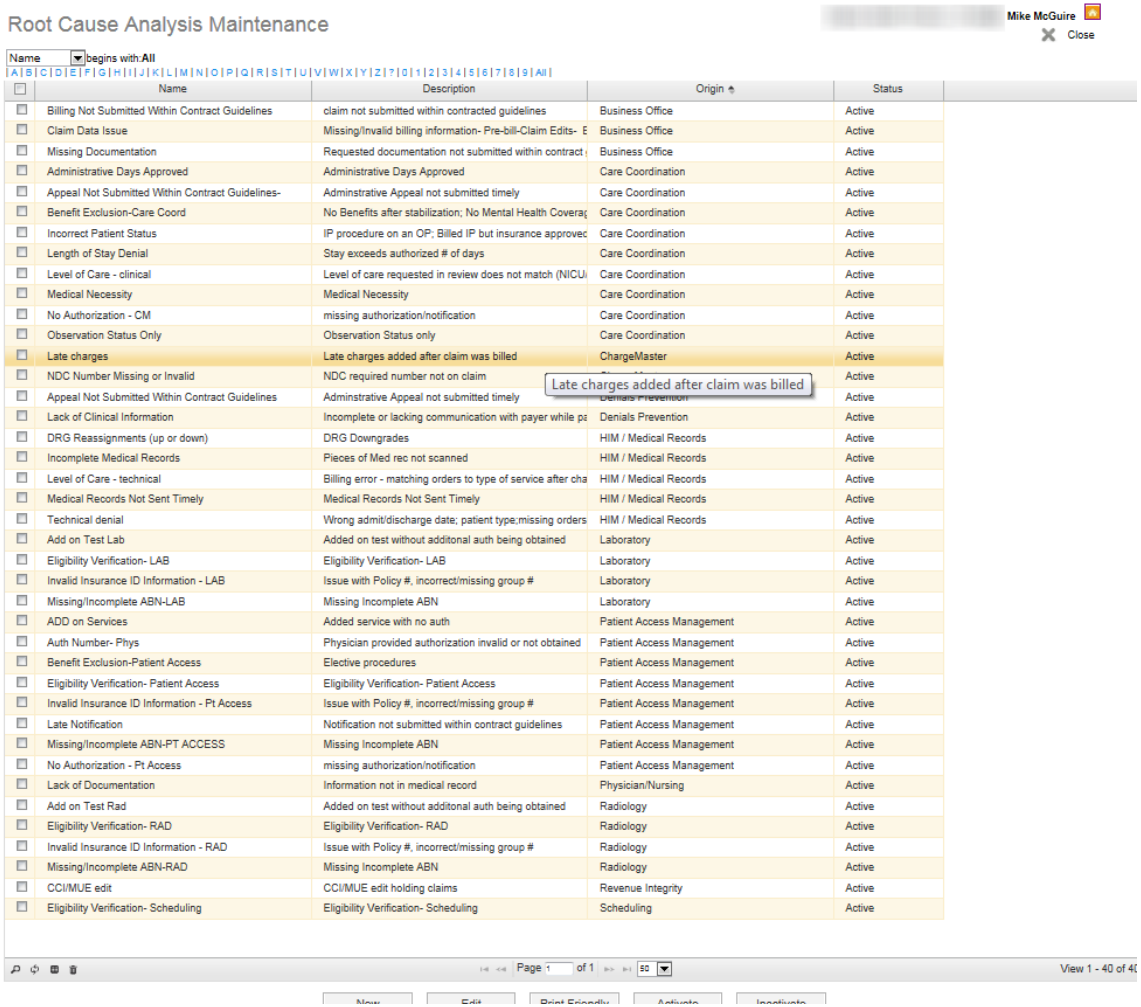
# Sources

- Remittance files
- Explanation of benefits
- Payer correspondence
  - Requests for further information such as medical records, itemized bills, claim attachments, patient coordination of benefits
- Claim edits, responses from clearinghouse
- Suspense files
- RAC and Post Payment Reviews

## Leveraging Technology

- Improve Processes
- Enhance Employee Productivity
- Exception Based Workflow
  - Focus on Value Added Work
  - Denial Management
- Improved Analytics
  - Real Time  Scorecards
  - Service Line Profit and Loss

# What is the true Root Cause?



Root Cause Analysis Maintenance

Mike McGuire

Close

Name begins with: All

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z | ? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | All

| Name | Description | Origin | Status |
|---|---|---|---|
| Billing Not Submitted Within Contract Guidelines | claim not submitted within contracted guidelines | Business Office | Active |
| Claim Data Issue | Missing/Invalid billing information- Pre-bill-Claim Edits- E | Business Office | Active |
| Missing Documentation | Requested documentation not submitted within contract | Business Office | Active |
| Administrative Days Approved | Administrative Days Approved | Care Coordination | Active |
| Appeal Not Submitted Within Contract Guidelines- | Adminstrative Appeal not submitted timely | Care Coordination | Active |
| Benefit Exclusion-Care Coord | No Benefits after stabilization; No Mental Health Coverag | Care Coordination | Active |
| Incorrect Patient Status | IP procedure on an OP; Billed IP but insurance approvec | Care Coordination | Active |
| Length of Stay Denial | Stay exceeds authorized # of days | Care Coordination | Active |
| Level of Care - clinical | Level of care requested in review does not match (NICU | Care Coordination | Active |
| Medical Necessity | Medical Necessity | Care Coordination | Active |
| No Authorization - CM | missing authorization/notification | Care Coordination | Active |
| Observation Status Only | Observation Status only | Care Coordination | Active |
| Late charges | Late charges added after claim was billed | ChargeMaster | Active |
| NDC Number Missing or Invalid | NDC required number not on claim | | Active |
| Appeal Not Submitted Within Contract Guidelines | Adminstrative Appeal not submitted timely | | Active |
| Lack of Clinical Information | Incomplete or lacking communication with payer while pa | Denials Prevention | Active |
| DRG Reassignments (up or down) | DRG Downgrades | HIM / Medical Records | Active |
| Incomplete Medical Records | Pieces of Med rec not scanned | HIM / Medical Records | Active |
| Level of Care - technical | Billing error - matching orders to type of service after cha | HIM / Medical Records | Active |
| Medical Records Not Sent Timely | Medical Records Not Sent Timely | HIM / Medical Records | Active |
| Technical denial | Wrong admit/discharge date; patient type;missing orders | HIM / Medical Records | Active |
| Add on Test Lab | Added on test without additonal auth being obtained | Laboratory | Active |
| Eligibility Verification- LAB | Eligibility Verification- LAB | Laboratory | Active |
| Invalid Insurance ID Information - LAB | Issue with Policy #, incorrect/missing group # | Laboratory | Active |
| Missing/Incomplete ABN-LAB | Missing Incomplete ABN | Laboratory | Active |
| ADD on Services | Added service with no auth | Patient Access Management | Active |
| Auth Number- Phys | Physician provided authorization invalid or not obtained | Patient Access Management | Active |
| Benefit Exclusion-Patient Access | Elective procedures | Patient Access Management | Active |
| Eligibility Verification- Patient Access | Eligibility Verification- Patient Access | Patient Access Management | Active |
| Invalid Insurance ID Information - Pt Access | Issue with Policy #, incorrect/missing group # | Patient Access Management | Active |
| Late Notification | Notification not submitted within contract guidelines | Patient Access Management | Active |
| Missing/Incomplete ABN-PT ACCESS | Missing Incomplete ABN | Patient Access Management | Active |
| No Authorization - Pt Access | missing authorization/notification | Patient Access Management | Active |
| Lack of Documentation | Information not in medical record | Physician/Nursing | Active |
| Add on Test Rad | Added on test without additonal auth being obtained | Radiology | Active |
| Eligibility Verification- RAD | Eligibility Verification- RAD | Radiology | Active |
| Invalid Insurance ID Information - RAD | Issue with Policy #, incorrect/missing group # | Radiology | Active |
| Missing/Incomplete ABN-RAD | Missing Incomplete ABN | Radiology | Active |
| CCI/MUE edit | CCI/MUE edit holding claims | Revenue Integrity | Active |
| Eligibility Verification- Scheduling | Eligibility Verification- Scheduling | Scheduling | Active |

Late charges added after claim was billed

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New | Edit | Print Friendly | Activate | Inactivate

# Moving to Denial Prevention

# Denial and Underpayment Sources

## Issues are created end-to-end in the business system

- Which means the solution will require end-to-end engagement

| Front | Middle | Back |
|---|---|---|
| • Max benefit hit<br>• Covered by another payor<br>• Member not eligible<br>• Member not found<br>• Non-covered charges<br>• Precertification or Authorization required<br>• Pre-existing condition<br>• Provider out of network<br>• Terminated coverage | • Additional clinical information required<br>• Bundle<br>• Diagnosis / code mismatch<br>• Medically not necessary<br>• Missing claim information<br>• Missing modifiers<br>• Non-covered service<br>• Wrong payor | • Additional claim information required<br>• Duplicate claim<br>• Incorrect contractual payment (short pay)<br>• Previously paid claim |

# Denial Prevention Action Items

- Identify denial trends and root causes
- Specialized Denial Analysts
- Reduce denials and related write-offs
- Increase cash flow and payment recovery
- Increase productivity through automation

# Innovative Approaches

# Project # 1 CPT Codes Missing and Project #2 Modifier missing

- Issue: Claims drop without CPT/HCPC codes or appropriate modifiers. These claims are sent to HIM for review. Many times the claim fails an edit in the billing scrubber (Optum or Other) and then there is a process of communication back to HIM via a workflow tool or email

- For Dignity Phoenix this issue represents 10% of all communication into HIM from PFS. At any point there is $3 Million in A/R waiting on a response.

- Innovation: Use the Optum **N**atural **L**anguage Processing (NLP) to scan the med rec to find the needed CPT code or determine if a procedure was completed multiple times. Information would go to HIM to determine if a modifier was needed or if charges need to be reversed.

  – Testing currently occurring
    - 1. If NLP can scan the Med Rec for the missing procedure and assign a recommended CPT/HCPC to be added to the patient record.
    - 2. If NLP can determine if the procedure needing a modifier was done multiple times and provide the med rec data to prove the need for a modifier or reverse of charges

# Project #3 – Work with CAC Team to make some edits hard stops

- Issue: Claims hitting billing edits that require HIM to review procedure codes and diagnosis together
- Volume: For Dignity Phoenix  - This issue accounts for approximately 49% of the assist/task volume or $12M
- Innovation: Use the Optum CAC coding system to **stop** CCI edits or national billing edits that require HIM feedback for resolution to be reviewed at time of billing
  - Testing:
    - 1. Determine if the billing edits for DX review hit a edit within CAC coding system. IF yes, review all edits in CAC against hard stop edits in billing systems to create a hard stop in HIM CAC so these must be addressed at time of coding.
    - This project would require a CAC edit listing and compare that to the Billing Scrubber Edit listing; determining which of the edits are hard stop within billing and creating that hard stop in CAC.

# Project # 4 – Patient Access Review

- Issue: Even with strong technology in Mede-Analytics human error  still occurs within scheduling and registration resulting in denials for eligibility
- Volume: Current weekly initial denials for eligibility and no authorization result in approximately $6M
  - This project is to determine if NLP can scan patient records and scanned documents (drivers license, insurance cards ,etc) and compare that with the registration documents to determine differences in name, group or insurance numbers.
  - Secondly this project can determine if NLP can review the medical record for the physician name should that be missing from the record.  PFS can review with patient access if physician name and NPI is missing
  - Third was additional procedures added to the account – Could this information be flagged to help identify when new authorizations are needed?


THANK YOU!

Traci Adair