Managing Denials: Covering all the Bases

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Presenting Today

**Jon Souder – Director, Revenue Performance Management**

Jon is a Director in PwC’s Health Industries Advisory practice focused on Revenue Cycle Management. He is a seasoned healthcare executive with over 16 years of consulting experience focused entirely on healthcare. In his career Jon has led back office centralizations for large, multi-hospital health systems, led post-merger integrations for large business process outsourcing groups, and worked with private-equity firms to improve performance in their healthcare portfolios. Most recently, Jon has focused his attention of helping established integrated delivery systems and new healthcare entrants to understand changing consumer expectations and the anticipated impact on how we manage the revenue cycle process from pre-access functions like scheduling and financial clearance through the back-office collections process.

**Jacob Shurbet – Manager, Revenue Performance Management**

Jacob is a Manager in the PwC Health Industries Advisory Revenue Performance Management practice. Jacob has spent most of his career specializing in revenue cycle strategy, redesign and workflow software implementation. He has worked extensively with several nationally recognized healthcare systems assisting with shared service design and implementation as well as co-leading several large scale transformational initiatives. Jacob has specifically been involved in complex redesign engagements focused on process reengineering and organizational restructuring in an effort to achieve significant financial improvement. Most recently, Jacob has been a part of several engagements focusing on A/R reduction, business office consolidation and process improvement to reduce cost and improve revenue for a prominent outpatient physician network. This work involved understanding the operational structure of large-scale health systems and working with clients to make critical changes in order to drive sustainable value.
Most health systems lose between 3 and 5 percent of their net revenue as a result of payment denials\(^1\)

The cost to denials makes up an estimated 20% of revenue cycle expenses\(^2\)

90% of denials are preventable\(^3\) when feedback from denials management is implemented with associated departments

Source:
1. Modern Healthcare
2. HFMA – Creating a Healthy, Unified Revenue Cycle
Scope of the Challenge

At 3-5% of NPSR, the State of Texas is leaving $2.3B on the table as a result of denied claims. And this doesn’t even include the cost of working these denials. But we have clients that are operating as low as 0.12% denial write-offs.

$255B Gross
$76.5B* NPSR
$2.3B left on the table

*Assumes 30% net to gross

Source: FY16 PwC Consortium Benchmarking Data
**Why so much $$$ left on the table?**

- Decentralized/dispersed accountability
- Informal processes around the prioritization of prevention initiatives
- Non-standardized practices to work denials
- Informal status reporting and progress monitoring processes and tools
- Triaged by denials team to functional area that owns the underlying root-cause process error (owner based distribution)
- Appeals researched and worked by staff with other competing responsibilities
- Separate reporting by entity

**Big Picture:**

- Simply managing denials does not correct the problem. Instead, organizations must **prevent denials**. Every time a claim gets denied, dollars leak from the Texas healthcare ecosystem (foregone revenue and additional organizational spend).¹

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Source:

1. AHIMA – Don’t Deny the Denials
So how do we prevent these denials

It’s the fundamentals - Successful denials prevention is pegged to successful implementation of 4 fundamental strategies

- Formally chartered, cross-functional teams
- Formalized processes
- It starts at the top - CFO
- Accountability that flows through the organization

- Embrace it, don’t hide it
- CARC and RARC code based taxonomy
- Visually trend data to more easily find patterns and prioritize work
- Proactive management/analytics

• Formalized feedback processes and tools
• Formalized management of prevention initiatives
• Escalation processes for initiative road-blocks
• Centralized initiative status reporting

• Joint operating councils (cross-functional) to provide feedback to payers, managed care, and departments
• Aggressive appeals
• Managed care strategy
Culture of accountability – Formally chartered, cross-functional teams

Denials Governance
- Rev Cycle leadership
- Vice Chairs of each Rev Cycle functional area
- Representation from IT, Denials Reporting, Denials Project Support, payer contracting, & clinical representation

Denials Prevention
**Responsibilities:**
- Denial root cause research
- Accountability assignment and work planning
- Communication with major payers
- Implementation of prevention projects
- Monitoring, review, and report outs to governance

Denials Recovery
**Responsibilities:**
- Denials appeal
- Denials follow up
- Denials closure (rebilling, write-offs, or next responsible party)

Denials Support
**Responsibilities:**
- Denials Reporting
- Denials categorization maintenance
- Denials trending analysis
- Prevention project implementation support
- Develop denial Key Performance Indicators (KPI’s)
**Culture of accountability – Formalized processes**

**ART conducts further research to validate underlying root causes for each denial**

**Denials Recovery staff sample accounts to validate initial segmentation and adjust as necessary**

**Data is monitored to ensure success of intervention**

**Segments are prioritized for prevention based on net revenue loss, net write-offs/recovery ratio, and resource requirements**

**The prevention team collaborates to identify a People, Process, or Technology fix and draft the project workplan**

**The prevention team works with functional areas to execute the project workplan**

**Charter Prevention Team**

**Implement Fix**

**Multiple prevention projects launched simultaneously**

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**LEGEND:**

Data Analysis → Prevention Implementation

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PwC
**Culture of accountability – Accountability that flows through the organization**

Regardless of how you develop your governance or workflow, accountability has to flow through your organization so denials don’t fall through the cracks.

Concentrating denials recovery to a specific team within follow-up allows for specialization and optimal staff resource allocation (flexing). These staff work 100% of denial volume.

**Remittance advice posted from payers with ANSI denials codes**

**ANSI codes mapped to custom categorization**

**Patient billing system distributes denials to work queues based on mapping**

**Denials team works to recover most denials**

**Denials team triages some denials to functional areas when needed**

Rev Cycle functional area staff only work denials where necessary (i.e. not all Access denials are worked by Access staff). Access & Coding will each be staffed to work an additional 3% of denial volume.

**LEGEND:**

- Denials are routed
- Denials are worked
**Culture of accountability**

- A CFO who is passionate about the Revenue Cycle

- Based on root cause denial analytics, every denial is assigned to a **single individual** for resolution

- Very transparent financial reporting of denials – external audit-proofed

- Closed feedback loops to follow up on denials and initiatives that must be pushed down to the departments for follow-up or implementation
Focus on prevention

Fixing the root cause of denials has a much larger financial impact than overturning them.

Probability of Collection

Denial Type
- Non-covered Service
- Missing Documentation
- Untimely Filing
- Ineligible on Date of Service
- Missing Authorization
- Duplicate Claim
- Coordination of Benefits
- Invalid CPT or HCPCS Code

Preventability
- Low
- Medium
- High

Probability of Collection
- Low
- Medium
- High

Source:
1. HFMA
**Focus on prevention – Formalized feedback processes and tools**

As denials are reviewed and root causes are identified, formalized processes and tools ensure they get to the right step along the claims journey.

- **Patient Access / Financial Clearance**
- **Patient Accounting System Rules**
- **Billing Rules**
- **Initial Denials and Write-offs**

- **Long-term Process Fixes**
- **Short and Long-term Stops and Technology**
Focus on prevention – Formalized management of prevention initiatives

A Denials Management Repository tracks denials prevention initiatives through their multiple phases and serves as an enterprise-wide knowledge base for denials.

The file is organized by process phases

SEGMETATION

<table>
<thead>
<tr>
<th>Segment ID</th>
<th>Segment Description</th>
<th>Cat</th>
<th>Reason Codes</th>
<th>Q2 2016 Denials</th>
<th>Action Plan</th>
<th>Root Cause</th>
<th>Linkages &amp; Dependencies</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>101.1a</td>
<td>Root cause outlined for each segment</td>
<td>COB 101</td>
<td>54,100,000 4.2%</td>
<td>13442005 4788212</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant enterprise information that may affect results through revenue being lost or uncharged</td>
<td>Changeable</td>
</tr>
<tr>
<td>101.1b</td>
<td>Root cause outlined for each segment</td>
<td>COB 110</td>
<td>4,800,000 4.9%</td>
<td>13442005 4788212</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant enterprise information that may affect results through revenue being lost or uncharged</td>
<td>Changeable</td>
</tr>
<tr>
<td>102.2a</td>
<td>Root cause outlined for each segment</td>
<td>COB 121</td>
<td>8,100,000 4.6%</td>
<td>13442005 4788212</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant enterprise information that may affect results through revenue being lost or uncharged</td>
<td>Changeable</td>
</tr>
<tr>
<td>102.2b</td>
<td>Root cause outlined for each segment</td>
<td>COB 122</td>
<td>2,900,000 4.1%</td>
<td>13442005 4788212</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant enterprise information that may affect results through revenue being lost or uncharged</td>
<td>Changeable</td>
</tr>
<tr>
<td>102.2c</td>
<td>Root cause outlined for each segment</td>
<td>COB 123</td>
<td>2,900,000 4.1%</td>
<td>13442005 4788212</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant enterprise information that may affect results through revenue being lost or uncharged</td>
<td>Changeable</td>
</tr>
<tr>
<td>Total</td>
<td>$ 100,000,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Each reason code divided into homogenous segments
Root cause outlined for each segment
Progress monitored on an ongoing basis
# Transparent reporting – CARC and RARC code based taxonomy

One of 300+ Claim Adjustment Reason Codes (CARC) code helps organizations tie a denial category to a specific service / department.

<table>
<thead>
<tr>
<th>CARC</th>
<th>Description</th>
<th>Denial Type</th>
<th>Department</th>
<th>Denial Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Deductible Amount</td>
<td>Information</td>
<td>Patient Liability</td>
<td>Patient Liability</td>
</tr>
<tr>
<td>2</td>
<td>Coinsurance Amount</td>
<td>Information</td>
<td>Patient Liability</td>
<td>Patient Liability</td>
</tr>
<tr>
<td>3</td>
<td>Co-payment Amount</td>
<td>Information</td>
<td>Patient Liability</td>
<td>Patient Liability</td>
</tr>
<tr>
<td>4</td>
<td>The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Modifier</td>
</tr>
<tr>
<td>5</td>
<td>The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Procedure</td>
</tr>
<tr>
<td>6</td>
<td>The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Procedure</td>
</tr>
<tr>
<td>7</td>
<td>The procedure/revenue code is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Procedure</td>
</tr>
<tr>
<td>8</td>
<td>The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Procedure</td>
</tr>
<tr>
<td>9</td>
<td>The diagnosis is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>10</td>
<td>The diagnosis is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>11</td>
<td>The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>12</td>
<td>The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Coding</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>13</td>
<td>The date of death precedes the date of service.</td>
<td>Preventable</td>
<td>Billing</td>
<td>Claim Error</td>
</tr>
<tr>
<td>14</td>
<td>The date of birth follows the date of service.</td>
<td>Preventable</td>
<td>Billing</td>
<td>Claim Error</td>
</tr>
<tr>
<td>15</td>
<td>The authorization number is missing, invalid, or does not apply to the billed services or provider.</td>
<td>Preventable</td>
<td>Financial Clearance</td>
<td>Authorization</td>
</tr>
<tr>
<td>16</td>
<td>Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Billing</td>
<td>Missing Information</td>
</tr>
<tr>
<td>17</td>
<td>Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance AdviceRemark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>Preventable</td>
<td>Billing</td>
<td>Missing Information</td>
</tr>
<tr>
<td>18</td>
<td>Exact duplicate claim/service (Use only with Group Code OA except where state workers’ compensation regulations requires CO)</td>
<td>Information</td>
<td>Duplicate</td>
<td>Duplicate</td>
</tr>
</tbody>
</table>
Transparent reporting – Visually trend data to more easily find patterns and prioritize work

Control charting can be used to identify outlier clinics/departments/providers. This information can then be used to prioritize prevention initiatives and denial recovery efforts.
Transparent reporting – Visually trend data to more easily find patterns and prioritize work
Transparent reporting – The evolution to predictive analytics

Traditional Approach

Root Cause Analysis
How and why did it happen?

Data Analytics and Benchmarking
What happened?

Future Approach

Predictive Modeling
What will happen if this changes?

Proactive Decision Making
What is the next best action?

Source:
1. HFMA
Payer Relations – Joint Operating Councils

Joint Operating Committee

Dedicated Denial Specialists
Utilization Management RNs
Physician Advisors
Legal Professionals
Culture of accountability – Helpful tips

1. Develop a denial management guide with detailed policy and procedures for employees (i.e. how to assign manually recorded denials to the appropriate denial code, how to appeal by denial type, etc.)

2. Enable employees to work denials more efficiently by providing technology and training to effectively work denials

3. Utilize automation to route denied claims to a staff’s worklist

4. Perform root-cause analysis to determine needed process changes and/or educate departments to prevent future denials

5. Provide periodic refreshers to educate staff on payer trends, updates in the insurer’s requirements for resubmitting claims, etc.

6. Implement a formal escalation process by denial type and dollar value for when staff need to resolve an issue or receive a response from a department (i.e. provide an example of the escalation process)

7. Utilize a write-off approval process with established dollar thresholds and management level approvals

8. Establish automated adjustments for low dollar denials and analyze using reporting to reduce denial costs
# Dedicated Analytics and Reporting Teams

A special Analytics and Reporting Team was created to support reporting functions, including categorizing CARC codes, compiling, distribution, and maintaining denials reports, and supporting denials prevention teams.

## 1. Categorization

- Mapping of ANSI CARC and RARC codes to custom client denials categories that are indicative of the underlying root cause
- Recommended mapping of all CARCs, as well as some RARCs and differentiation by payer where necessary

**Note:** CARC mapping will be reviewed and approved by the Denials Governance Committee

<table>
<thead>
<tr>
<th>CARC</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
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<td>3</td>
<td>C</td>
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<td>4</td>
<td>D</td>
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<td>5</td>
<td>E</td>
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<td>F</td>
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<td>7</td>
<td>G</td>
</tr>
<tr>
<td>8</td>
<td>H</td>
</tr>
</tbody>
</table>

## 2. Reporting

- Denials reporting maintenance & administration, including distribution lists, distribution platforms, and maintenance of accountability assignments
- Regularly cadenced denials surveillance and trend analysis
- Denials overview presentations

**Note:** Denials reporting will be prioritized, reviewed, and approved by the Denials Governance Committee

## 3. Prevention Support

- Data analysis to recommend prevention initiatives and prioritization
- Project management support for denials prevention initiatives:
  - Team charting / goal setting
  - Workplan & milestone development
  - Metric tracking
- Denials Recovery review and management
**Recommended Organizational Structure for Denials Committees**

Consider a future state organizational structure that more effectively aligns functions across the revenue cycle, and consists of a cross-functional Denials Management team.

1. Sub-Committees should include clinical and medical representation, e.g. case management, physicians, etc.
**Next Steps**

1. Complete a denials assessment
   - Claims denied by reason
   - Dollars denied / adjusted
   - Claims denied and reworked
   - Dollars / claims appealed and recovered
   - Cost of rework
   - Review / update denial processes
2. Identify organizational staffing opportunities
3. Streamline processes to optimize workflow
4. Engage and educate physicians and staff on improvements
5. Develop and implement prevention strategies
6. Set reduction goals!
### Case Study in Preventing Denials

#### Denials Governance

**Responsibilities:**
- Denials reporting prioritization and approval
- Goal & target metric setting
- Prevention project prioritization & chartering
- Resource assignments
- Approval of policies and procedures

**Composition:**
- Rev Cycle leadership
- Vice Chairs of each Rev Cycle functional area
- Representation from IT, Denials Reporting, Denials Project Support, payer contracting, & clinical representation

**Organizational Department:**
- Separately assigned committee
  - OR
  - Subset or designated time in RCLT meetings (IT/Reporting/Support invited)

#### Denials Prevention

**Responsibilities:**
- Development of workgroups and detailed workplans for each denials prevention project
- Establish lines of communication with major payers
- Implementation of prevention projects
- Monitoring, review, and report outs to governance on prevention status
- Reviewing detailed reports drilling into the cause of denials

**Composition:**
- Each Denials prevention initiative will be assigned an owner by the governance committee
- Individual team group members will be appointed by the project owners
- Revenue Cycle Operations Analysts can be involved as needed

**Organizational Department:**
- Prevention teams are staffed from the functional area where the project is focused
- Includes representation from Analytics Reporting Team (ART) to support prevention initiative

#### Denials Recovery

**Responsibilities:**
- Denials appeal
- Denials follow up and root cause research
- Denials closure (rebilling, write-offs, or next responsible party)

**Composition:**
- Denials will primarily be worked by dedicated denials team
- Denials that the team are unable to work, due to lack of access or competencies, will be automatically routed or manually triaged to other functional areas
- Governance will approve the routing and triaging of denials, and receiving departments will formally accept responsibility for recovery

**Organizational Department:**
- Denials staff located in the Enterprise Denial Management team will work most denial appeals
- Some resources in other Revenue Cycle functional areas dedicated to denials

#### Denials Support

**Responsibilities:**
- Denials Reporting (regularly cadenced dashboards)
- Denials categorization maintenance
- Denials trending analysis
- Prevention project implementation support, including project management
- Develop denial Key Performance Indicators (KPI’s)

**Composition:**
- Reporting expertise (Clarity, SQL, Epic Graph Package, Reporting Workbench, Cleopatra)
- Prevention support expertise, including staff specializing in project management and performance improvement

**Organizational Department:**
- Housed in the Denials Management and Analytics Reporting Team (ART) within BAR