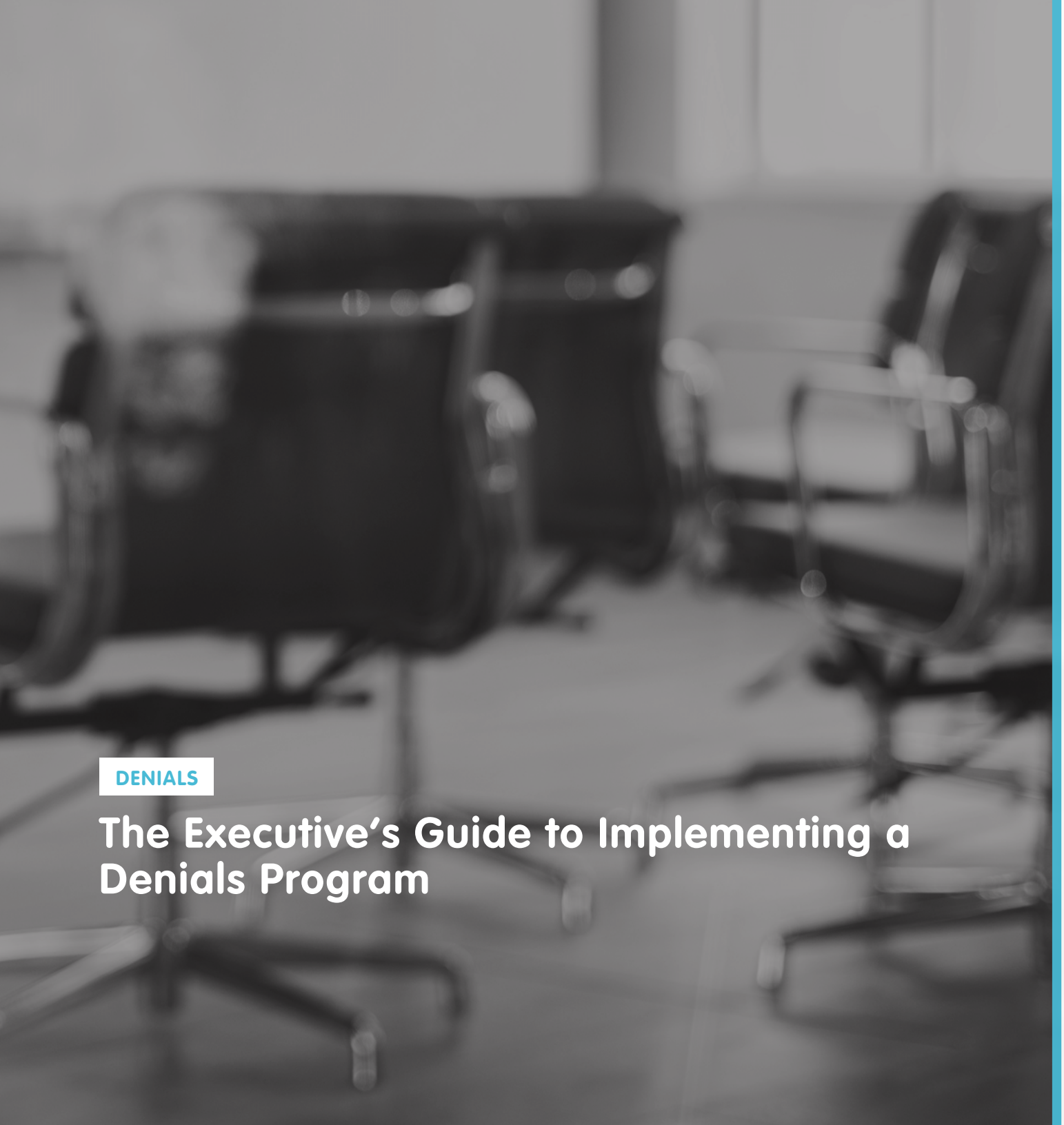


DENIALS

The Executive's Guide to Implementing a Denials Program

VYNE MEDICAL

Connecting Disconnected Data®

At Moffitt Cancer Center, a robust denial prevention program resulted in reducing denials from 14% of gross charges to 8% of gross charges billed.

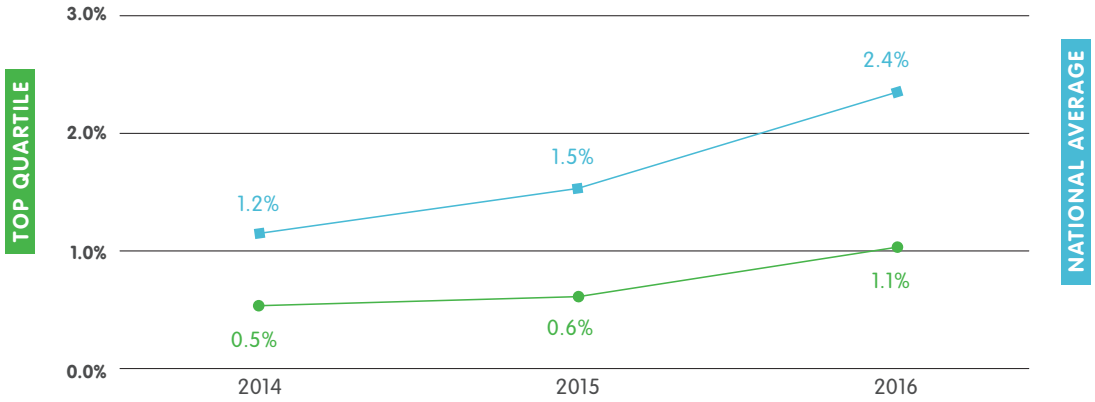
The process involves a multidisciplinary team, a data-driven strategy, a preventative approach and a missional, patient-centric perspective that extends across the organization.

It's no secret that denials are costing you money - a greater percentage of net patient revenue every year by some accounts. Change Healthcare analysts estimate[2] that of the approximately $3 trillion in claims submitted by hospitals in 2016, 9% of charges were initially denied - that's $262 billion. As many as one in five claims are denied or delayed, according to PNC Financial Services Group.

What does that look like for the typical health system? That equates to as much as 3.3% of Net Patient Revenue, an average of $4.9 million per hospital, at risk due to denials.

Healthcare leaders are familiar with the steps it takes to overturn denials, but preventing them is more cost effective. Research (The Advisory Board) shows that about 2/3 of denials are recoverable, and 90 percent are preventable. Hospital leaders must work aggressively to prevent denials while continuing to fight those that occur. This requires consistent processes, reliable tools and collaboration between all areas that support the denials management program.

DENIAL WRITE-OFFS AS A % OF NET REVENUE: 3-YEAR TREND[1]



SOURCE: JANUARY 2014–JANUARY 2016 – HBI REVENUE CYCLE SCORECARD

"For us, a denials prevention program looks to identify what we can do on the admin and clinical side to prevent denials, and what are we willing to accept for the betterment of our patients."

– JOANNA WEISS, VP OF REVENUE CYCLE
MOFFITT CANCER CENTER

A denials prevention program is a formalized, multidisciplinary initiative to strategically reduce the likelihood of claims being denied by payers. How does this differ from traditional denials management? According to HFMA[3], **"Rejection Prevention is a shift from a system designed to 'work' denials to a system that is designed to provide meaningful data into the organization in order to identify the rejections that can be prevented and to take meaningful action in improving upfront revenue cycle processes."**

You won't know if you need a denials prevention program unless you're tracking the right data. This can include:

- Gross AR days
- Gross AR Aged Percentage Under 90 Days
- Denial Write-offs as a Percentage of Gross Revenue[3]
- Trial balance

As the leader of this initiative, you are responsible for defining the mission. Where is your organization now, how does it compare to best practice, what's a reasonable goal for Year 1, and how does a reduction in denials translate financially? You'll need this information not only to measure your success, but also to recruit participation in the initiative because you can't do it alone, which leads us to Step 1.

Step 1. Create a Steering Committee

TIME:

1 Month

POSSIBLE CHALLENGES:

Getting buy-in

Recruiting participants given the time commitment

Scheduling committee meetings that accommodate everyone's schedules

Executive Support

If you're not the executive sponsor, you need to get one. Having an executive sponsor attend committee meetings demonstrates to the team that this initiative is a priority. Because you'll want your committee to be multidisciplinary, recruiting both the CFO and the Chief Medical Officer is a good way to represent both financial and clinical interests and drive new processes forward across all critical areas of the organization.

Multidisciplinary Approach

A key to a successful denial prevention strategy is a multi-disciplinary approach with leaders representing both the clinical and financial sides of the organization. Opportunities to prevent denials exist throughout many functional areas outside of finance. Coding needs to know, for example, the importance of staying on top of payer policies and ensuring that claims are submitted with appropriate documentation. Your steering committee should include representation from Patient Access, Utilization Review, Health Information Management, the Business Office and clinical areas.

"Our steering group has representation from revenue cycle, physicians, radiation oncology, and case management." –Joanna Weiss, VP of Revenue Cycle

Getting Buy-in

Recruiting steering committee members might be challenging for some healthcare organizations, but it also might be easier than you anticipate as it was for the Moffitt Cancer Center. Here are some tips:

Communicate the value of this initiative by stating your goal and the impact it will have both on the organization as a whole and on each individual team. Show how the effort ties to your mission and the impact it will have for patients. At Moffitt, the goal of reducing administrative denials from $4 million to $2 million meant $2 million more to invest back in patient care.

"We are a mission-driven, patient-centric institution. One more dollar recovered represents one more dollar the Center can invest in curing and preventing cancer. That objective automatically garners excitement and engagement." –Joanna Weiss, VP of Revenue Cycle

Setting Expectations

Set realistic time investment expectations for employees and leadership: Moffitt estimates that for them, the total time spent on this project is probably half to three quarters of a full-time employee, or 120-140 hours a month between the report-out, presentations and meetings. VP of Revenue Cycle Joanna Weiss estimates she spends about 2 hours a month on their denials prevention initiative.

Schedule regular meetings, starting with a monthly meeting and then reassessing needs. It's possible that a monthly meeting won't be the best use of everyone's time, at which point you can switch to bimonthly meetings and designate subgroups, which can meet more frequently and focus on initiatives that are specific to their team.

Designate a project manager to oversee all tasks across teams, performing regular check-ins and monitoring progress. At Moffitt, the project manager spent 40% of her time on data trends and root cause analysis related to denials.

Sample Agenda

ATTENDEE **PRESENT?**

DENIAL CATEGORY	DISCUSSION ITEMS	OWNER	TIME ALLOCATION
	Introductions for any new members in the meeting.		1 to 2 minutes
All Denial Categories	Update on Action Items		5 minutes
[Month] Denial Dashboard	Report the Denial Dashboard for the month.		5 minutes
	Denial Dashboard: Overview of the Top Denial Oppurtunities by Payers/Categories based on a 25% variance. Review of Root Causes identified.		5 minutes
	Departmental Review: • Case Management • FCU • HIM • Denials		5 minutes
All Denial Categories	Report the Denial Dashboard for the month.		5 minutes
[Month] Denial Dashboard	Denial Dashboard: Overview of the Top Denial Oppurtunities by Payers/Categories based on a 25% variance. Review of Root Causes identified.		5 minutes
	Departmental Review: • Case Management • FCU • HIM • Denials		5 minutes
Denial Dashboard	FY 18 Subgroup Update		5 minutes
Discussion and decision making on the following questions:	What are the immediate next steps, owners, and timeframes? What are the action items for the next meeting?	Everyone	5 to 10 minutes

DECISIONS MADE / DISCUSSION OVERVIEW

ACTION ITEMS **OWNER** **TARGET DUE DATE**

Step 2. Perform Denials Root Cause Analysis

TIME:

1 Month

POSSIBLE CHALLENGES:

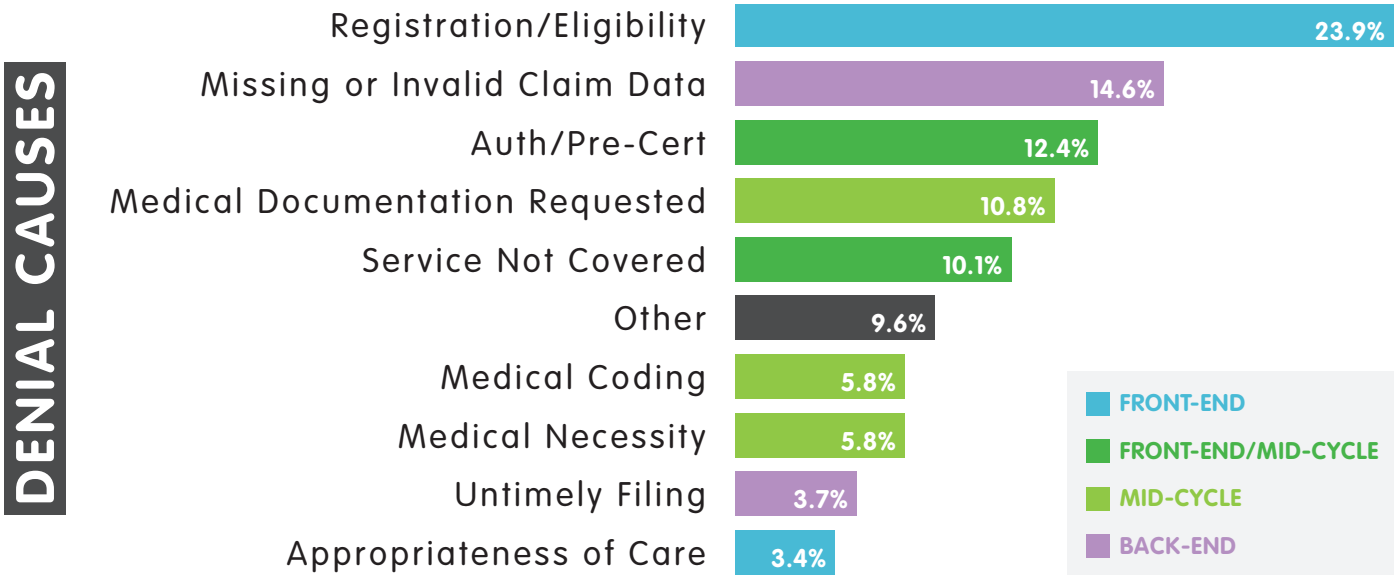
Identifying resources for data analysis

Constant changes to payer and regulatory requirements

Growing complexity of claims along with organization growth and addition of services

Determining Denial Causes

Trace the reasons for denials back to the processes from which they originated. Denials can be caused throughout the revenue cycle, but most commonly occur on the front end:



SOURCE: http://healthyhospital.changehealthcare.com/wp-content/uploads/2017/06/change-healthcare-healthy-hospital-denials-index-2017-06-a-2.pdf

It's critical that your denials prevention program is driven by data rather than anecdotes. Before the first meeting, perform some analysis to drive the agenda. HFMA Texas recommends visually trending the following data to find patterns and prioritize work:

- Claims denied by reason
- Dollars denied / adjusted
- Claims denied and reworked
- Dollars / claims appealed and recovered
- Cost of rework

Begin with a random sample of claims by payer and analyze each payer's use of codes. Then set a threshold to perform group analysis of any claim over a certain amount. Push the lower-hanging fruit out to individual departments for working. This allows the steering committee to remain at a high level while subgroups, which know their processes best, dive into the details of claim analysis.

Moffitt found that radiation oncology claims were being delayed or denied because, even though the diagnosis passed medical necessity, coding wasn't looking in the right place to get specificity needed for claims submission. This discovery led to recovery of millions of dollars in claims.

Targeting Solutions

Present data at your first meeting and discuss potential solutions as a group. Many issues can be resolved through staff training and/or new technology. Research shows that 30 to 40% of denials result from registration and pre-service related challenges, so this is a good place to start. The problem may stem from insufficient documentation, an issue on the payer side or any number of errors in patient access/registration, coding/billing or utilization/case management. Following are examples of potential issues and strategies to address them:

- Registration: Use business rules and tools to improve the accuracy, completeness and consistency of registration data. Fixing errors in real time helps prevent downstream denials.
- Eligibility: Ensure that staff perform thorough eligibility verification and confirm multiple times prior to the date of service.
- Pre-authorization: Secure authorization in advance, and update for any clinical changes. Important areas of focus include payer policy maintenance and medical necessity.
- Documentation: Document registration, eligibility and authorization activity (phone, fax and electronic) for evidence to support efficient coordination and reimbursement of patient care.

"Once the root cause is identified, it must be analyzed to determine which has the greatest impact: whether a certain physician, service line, or payer, a certain type of code, or a process in need of redesign in both the clinical and revenue cycle areas. Armed with an analysis, you can begin to both prevent and manage denials in a more strategic, deliberate manner." – Rethinking Denials Management, HealthLeaders Media[4]

Implementing Change

In cases where staff training is key to the initiative, it can be challenging to institute behavior change and encourage staff to adopt a denials prevention mindset across the revenue cycle. Many healthcare organizations find it helpful to record conversations staff members are having with payers, physicians and patients. Trace™ from Vyne Medical is a healthcare-specific solution that can record face-to-face and phone conversations to ensure key processes like eligibility verification are occurring and provide

Step 3. Create Plan for Improvement

TIME:

Depends on initiative

POSSIBLE CHALLENGES:

Instituting behavior change

Staying on top of changing payer regulations

Staff training/education

transparency to leadership if they're not. With Trace, conversations are indexed automatically to the patient's record for easy reference during staff performance evaluations.

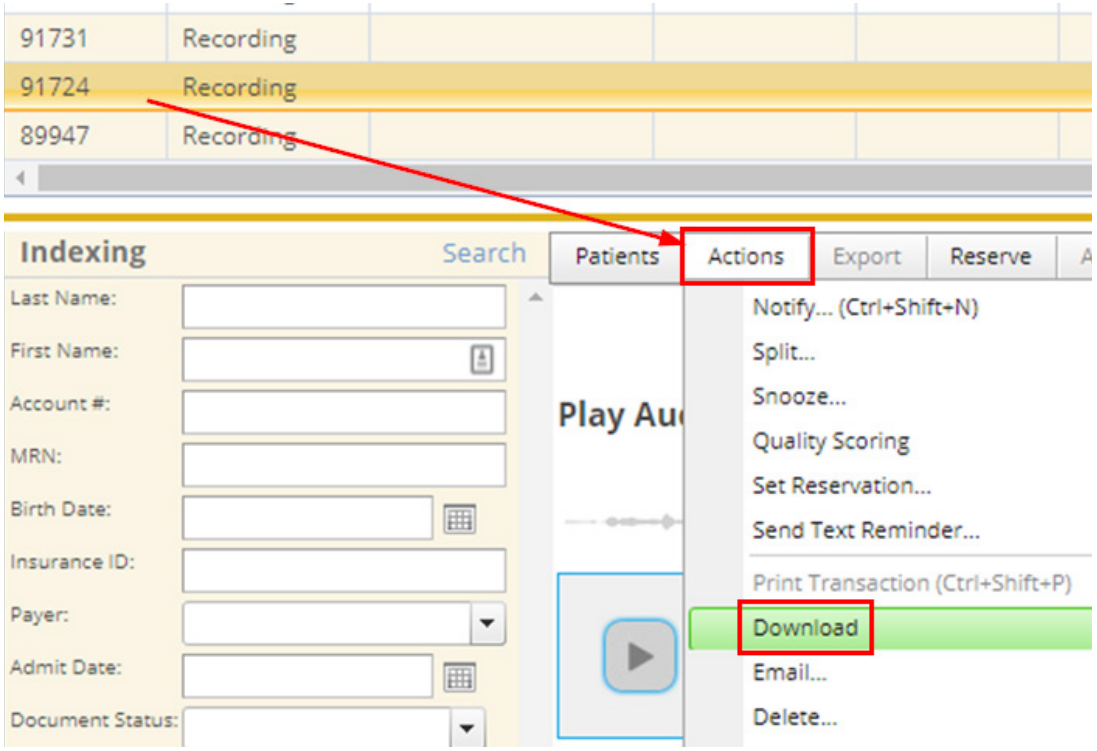
Payer Strategies

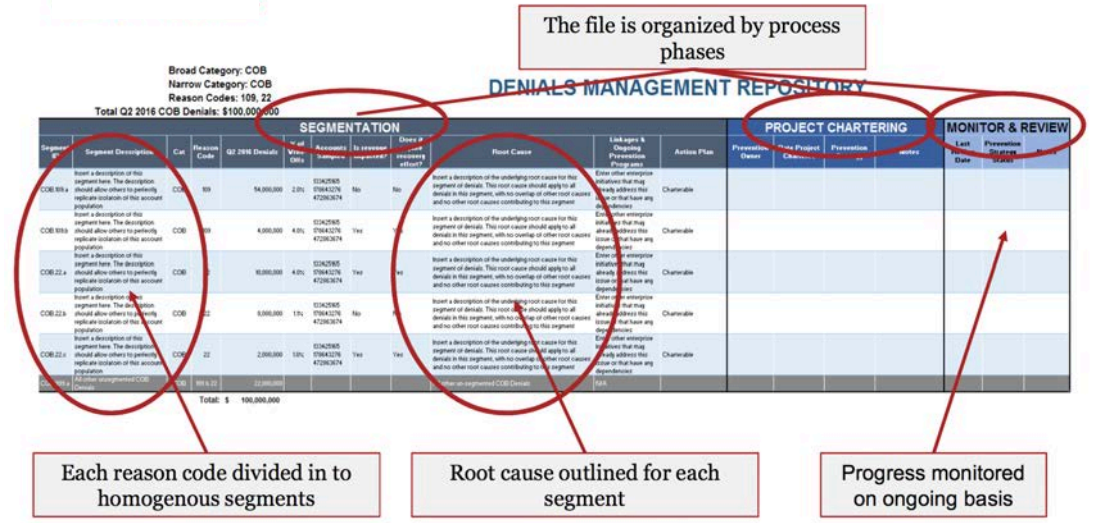
Culturally, it may also benefit your organization to reframe expectations of payers. Manage expectations internally and make sure employees understand that payers operate from a cost containment strategy. By improving payer relationships, it may be possible to eliminate contract requirements that frequently lead to denials. Schedule regular meetings with payers, and be able to provide examples when escalation does occur. Realistically, healthcare organizations will never be able to completely eliminate denials and should still be prepared when they occur. Solutions like Trace can also help hospitals overturn denials by enabling providers to easily capture critical interactions with payers online or over the phone, attach evidence of preauthorization to the patient record and quickly provide documentation if needed later on.

For Moffitt, documented proof of payer authorization sped up the appeals process and allows staff to appeal 20-25 claims per day versus 8 per day when appealing just on the basis of medical necessity.

Tracking Progress

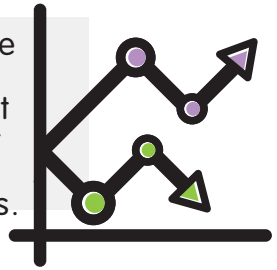
Once the team has agreed on their action items, the project manager should create a tracking document to manage initiatives across disciplines. Here's an example from HFMA Texas[5].

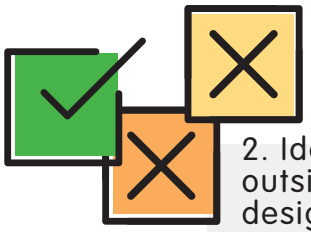




PROCESS SUMMARY

1. Compare data to the historical trend, keeping in mind that it may take up to a year to see the impact of process improvements.



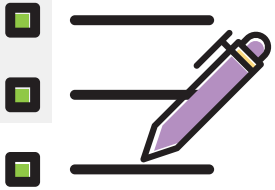


2. Identify anything outside your designated threshold.

3. Decide as a group how to dig into the details of that data.

4. Pull a sample and conduct root cause analysis

5. Add discussion topics to the agenda and ask the responsible group to report on their findings.



Continue to meet regularly and track key metrics.

As with any project, not every solution will be successful which is why ongoing tracking is so critical. If you're not seeing progress, make sure staff have implemented the new processes and they're properly trained on any new technologies, then evaluate whether additional actions are needed.

To help each area better understand its impact on denial performance, proactively share information about department-relevant denials and actions taken to appeal those claims. This is also an opportunity to conduct root cause analysis of recurrent denials and determine prevention strategies at the department level. At each level of the organization, goals and performance measures should be tied to denial performance for improved awareness and accountability. Send quarterly reports to executive and revenue cycle leaders to ensure transparency and insight across the organization.

Step 4. Ongoing Measurement and Improvement

TIME:

9-12 Months

POSSIBLE CHALLENGES:

Trial and error may be necessary to identify effective solutions

Timeframe of claim cycle means it can take a while to see impact of changes

Conclusion

"We've seen our denials go from 14% of gross charges to 8% of gross charges."
–Joanna Weiss, VP Revenue Cycle

As a financial leader, it's up to you to shift your organization toward a more proactive approach to denials. While denials prevention does require an additional time commitment, it's become a top priority for healthcare leaders across the country. While denials will never be eliminated, taking measures to prevent just a percentage of them from occurring will have a substantial impact on your organization's bottom line.

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