Insights and actions for successful results

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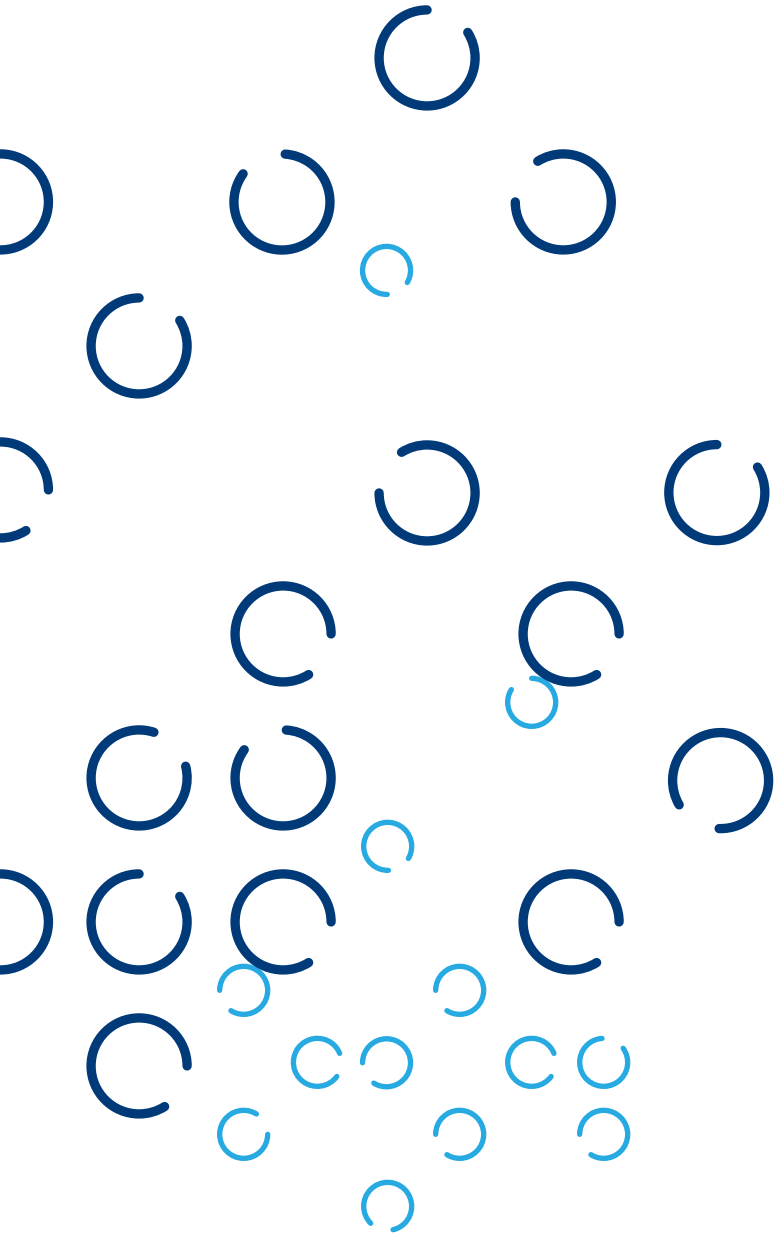

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Moffitt Cancer Center Reduces Certain Denials by Half

By Joanna Weiss, Lynne Hildreth, and Andy Talford

One discovery related to coding for specificity led to recovery of millions of dollars in claims.

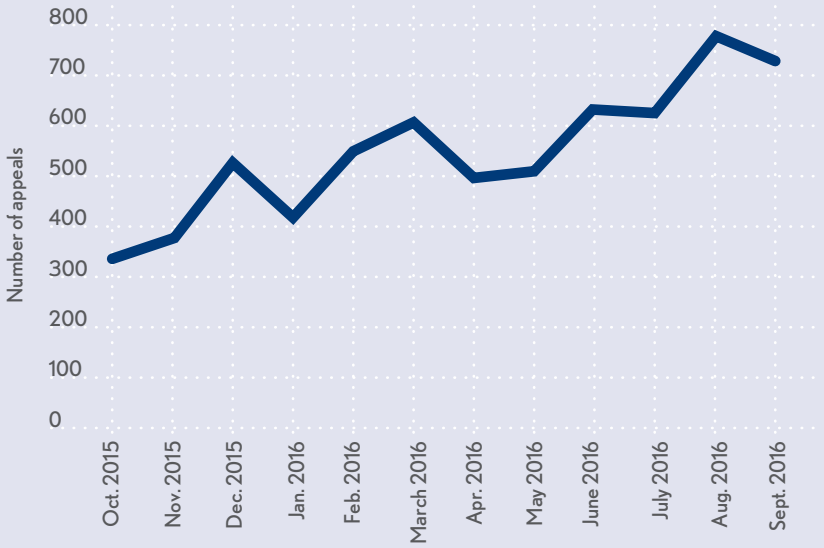
As an academic cancer center, denials are par for the course at Moffitt Cancer Center, Tampa, Fla., as payers consider some procedures cutting edge or experimental. Services are costly, and length of stay is longer than most. But we are committed to making these services available to patients even if they are not covered up front. So anything we can do from an administrative or clinical perspective to avoid preventable denials up front helps balance out those services we are willing and able to cover for patients.

Given this, we were facing significant challenges related to denials. We had grown and added services, making claims processing more complex, with patients transferring between specialists and often requiring submission of multiple claims. Increased scrutiny of oncology services, along with ongoing changes to payer requirements, heightened these challenges and had begun to negatively impact satisfaction among our referring physicians and patients.

Our goal in initiating a denials prevention strategy was to reduce the likelihood of claims being denied by identifying rejections that we could prevent on the front end. By working aggressively to prevent denials and continuing to fight those that occur, we could make headway in recovery efforts and put more resources toward patient care. To achieve this, we needed consistent processes, reliable tools, and collaboration among all areas involved in the denials management program.

Preventive Methods Increase Number of Appeals

Moffitt Cancer Center' shifted to a proactive appeals approach, allowing staff to appeal up to 25 claims per day versus 8 per day.



Source: Moffitt Cancer Center. Used with permission.

Multidisciplinary Steering Committee

The first step in our denials prevention program was forming a steering committee. Our committee includes leaders from revenue cycle, case management, physician leadership, and radiation oncology. Executive support also is key, and participation from our CFO sends a clear message about the importance of our committee's work to the organization.

It was imperative to involve both the clinical and financial sides of the organization on the committee. Involving clinical areas increases awareness of their role in the claims and billing process, particularly with issues related to medical necessity, coding, and documentation. To teach new practice patterns, we have found it beneficial for clinicians and physicians on the committee to educate clinical teams across the organization.

For example, our coders needed to know the importance of staying on top of payer policies and ensuring claims are submitted with appropriate documentation. The extra time taken to ensure each claim is as clean as possible prior to submission prevents having to overturn it with an appeal, speeding payment and cash flow.

Data-Driven Strategy

As a committee, our first priority was finding out why our denials were occurring in the first place. This required analyzing data to identify root causes for reoccurring problems. Our objectives were to track the number of denials, the dollar amounts associated with them, the reasons for those denials, and the payers involved.

Web Extra

View a denials committee sample agenda at hfma.org/rcs/DenialsCommitteeAgenda.

Every payer has a different way of adjudicating claims. For example, one of our payers frequently denies claims for bundling, while others use bundling as a contractual code. We began with a random sampling of claims by payer to identify how each was using codes. From that point, we set a threshold to perform group analysis of any claim more than a certain dollar amount.

Once the committee analyzes this data, we divide into subgroups for deeper analysis of denials and their sources. Subgroups then come back to the committee with their reports and action items to impact meaningful change. We also enlisted a project manager who helps identify data trends and perform root cause analysis of issues. She oversees tasks across teams and monitors progress with regular check-ins.

One discovery in this process was that radiation oncology claims were being delayed or denied because, even though the diagnoses passed medical necessity, our coders weren't looking in the right places to get the specificity needed for claims submissions. This discovery alone led to recovery of millions of dollars in claims. This case demonstrates the importance of being proactive in reaching out and sending relevant data and documentation rather than waiting for a payer to request additional information or deny a claim.

One of our center's top five key metrics is transparency, and it was imperative to our success that denials data be shared openly across the organization. As a committee, we pull data each month and compare it to historical trends. Quarterly reports are shared with executive leadership, along with department-relevant denials and actions taken to appeal those claims. At each level of the organization, goals and performance measures are tied to denial performance for improved accountability centerwide.

Denials Prevention with Proof of Authorization

Our appeals approach has changed significantly because of our shift to a preventive mindset.

Previously, clinical staff worked to overturn denials based almost entirely on medical necessity and not on payer authorization or eligibility requirements. Our new approach is to proactively get necessary preauthorizations and documentation in place to avert denials on the front end.

When staff talk with payers by phone or visit payer websites regarding patient benefits, they record those interactions and save recordings to the patient record for proof of authorization—or proof that a payer said authorization was not required. If a payer later denies a claim for lack of authorization, staff locate the recording and play it back or send a transcript to the payer. In these cases, the denial often is overturned. As an added step, we integrated this recording technology so that recorded exchanges—whether voice, fax, or image—are automatically exported to our electronic document management (EDM) system and accessible across the center when needed.

This documented proof has streamlined our appeals process, allowing staff to appeal up to 25 claims per day versus 8 per day when appealing solely on the basis of medical necessity. Submitting this documentation early in the process often stops the denial before it officially goes on the books and significantly shortens the appeals process. We have also observed a change in payer denial patterns since we began using recordings to establish proof of patient authorization, with the number of claims initially denied gradually decreasing over time.

Recording revenue cycle interactions also has reinforced accountability among staff regarding a preventive approach to denials. By recording conversations with payers, physicians, and patients, we can ensure that key processes like eligibility verification are completed accurately and consistently.

Metric-Driven Culture

At Moffitt, we adhere to the saying, "What gets measured gets done." One of the efforts that came out of the denials steering committee was initiating a metric-driven culture to measure the timeliness and completion of financial clearance activities.

To track and improve performance, the financial clearance unit initiated a new key performance indicator measuring the percentage of accounts completely cleared in a 14-day window. Completely cleared was defined as accounts that have been verified, authorized, and provided financial counseling. In this equation, the numerator is the number of accounts completely clear, and the denominator is the number of scheduled encounters from today until 14 days from now.

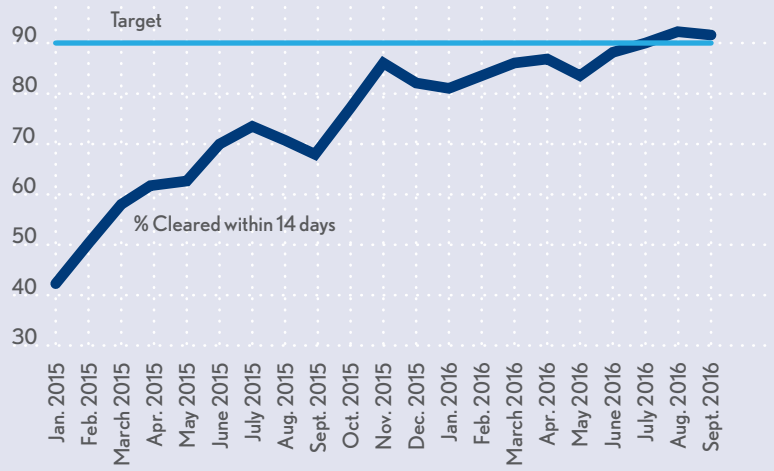
As a result of this new KPI and other denials-related efforts, we improved our 14-day clearance rate from 40 percent to 94 percent and doubled the number of appeals pursued each month. We are now winning two-thirds of authorization appeals and have reduced administrative denials by nearly half.

The overall impact of these efforts is that our revenue is up and our denials are down. We have been successful in reducing denials from 14 percent of gross charges to 8 percent of gross charges billed, translating into millions of dollars reinvested in patient care and our mission of curing and preventing cancer.

Change takes time, especially given the time frame of a claim cycle. And while denials will never go away completely, success can be found with processes to prevent denials and programs to enhance the appeals process for those that still occur. These efforts require further collaboration, integration, and communication across all areas of the organization. But the impact and return are well worth the resources invested. •

KPI Improves 14-Day Account Clearance

Moffitt Cancer Center's financial clearance unit initiated a key performance indicator measuring the percentage of accounts completely cleared in a 14-day window. As a result of this new KPI and other denials-related efforts, Moffitt improved its 14-day clearance rate from 40 to 94 percent.



Source: Moffitt Cancer Center. Used with permission.

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