Big Data and Analytics to drive Denial Management Bottom Line improvements

*Using Big Data and Analytics to drive sustainable denial management workflows that help improve the bottom line*

Thursday, December 1, 2016
Noon – 1:00 Pacific / 1:00 – 2:00 Mountain / 2:00 – 3:00 Central / 3:00-4:00 PM Eastern

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Summary of Session

During this webinar, speakers will address the latest industry trends for addressing denials and ways organizations can align people, process and technology to be successful.

The session will highlight a multi-pronged approach leveraging data-driven insights to enable decision making, operational effectiveness that incorporates leading practices and process standardization that can drive sustainable improvements for your organization.
Session Objectives

At the completion of the session, the participant will understand

• core components of a world-class denials management program

• how to translate denials data into meaningful insights, then into action and

• how data and process can be partnered to provide sustainable results
Focus Point #1
Denials Management – Today’s Environment
Denials Continue to be a Financial Burden for U.S. Healthcare Providers

<table>
<thead>
<tr>
<th>Denials</th>
<th>Reprocessing</th>
<th>Error</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4B</td>
<td><strong>3 Times</strong></td>
<td>42%</td>
<td>$5-10 MM</td>
</tr>
<tr>
<td>200 MM</td>
<td>$1 MM</td>
<td>2-5%</td>
<td>$30-$70MM</td>
</tr>
</tbody>
</table>

- Claims submitted annually:
  - 1.4B

- Claims denied—that is 1 in 7 claims:
  - 200 MM

- More costly to reprocess claims:
  - $1 MM

- Of write-offs from claim denials are the result of process breakdowns:
  - 42%

- Average write-offs/year for hospital to resubmit claims:
  - $1 MM

- Average write-offs/year for health systems due to preventable denials:
  - 2-5%

- Average write-offs/year for U.S. health systems:
  - $30-$70MM

- Annual lift in operating margin for a $1 billion health system by reducing claims denials by 0.5-1%:
Why the focus on Claim Denials?

- Process breakdown and operational inefficiencies
- Changing payor billing requirements and reimbursement complexity
- Unclean claim data
- Strained Payor/Provider relationships
- Varying degree of tool automation, workflow and analytics

1 out of every 7 insurance claims are denied
3x more Costly to re-process claim
0.5-1% of Net Revenue Loss annually for U.S. health systems

1 out of every 7 insurance claims are denied
3x more Costly to re-process claim
0.5-1% of Net Revenue Loss annually for U.S. health systems
Providers Face Multiple Revenue Cycle Related Imperatives

**Access and Consumerism**
- Increased consumer demand for ease of access and convenience
- Demand for digital/self-service options

**Value-Based Payment and Reimbursement**
- Drives continued margin compression; focus on reducing overall cost of care/cost to collect

**Pricing Transparency**
- Shift of cost burden to patients drives demand for up-front transparency
- Improved collection strategies required to manage Bad Debt

**Payer / Provider Convergence**
- Collaboration and consolidation
- Opportunities for simplification; additional channels for consumer engagement

**Acute / Ambulatory Integration**
- Driven by consumer-facing needs of administrative simplification and continued cost and efficiency pressure
Emerging Capabilities for Providers

New data sources and analytics enabled technology to rapidly respond and solve healthcare’s most challenging issues.
Focus Point #2
Denials Management – An Effective Operating Model
The Denials Management Goal

Shift from a reactive, retrospective review to a proactive multi-disciplinary approach that optimizes processes, leverages data analytics and technology to reduce revenue leakage.

Result in net revenue improvement and reduced cost that can be allocated to fund investment, innovation or be returned to stakeholders.
Strategies for Managing Denials Today

**Three (3) fundamental strategies**

- an **outcome-based management culture** that drives **accountability** *(People)*
- A **standardized, integrated, multi-functional solution** that incorporates leading practices and metrics *(Process)*
- **automated workflow tools and advanced data analytics** *(Technology)*
Optimized Operating Model

- Lower cost & maximize revenue
- Focus on high-value capabilities

- Focus on integration of end-to-end value chain
- Drive core business

- Identify disruptors and innovation concepts
- Identify, reduce and eliminate unrequired process & work-flow

- Drive activities that enhance operational performance
- Monitor and control outcomes
Optimized Operating Model - Focus on Care Management

An integrated CM model is critical to meet the leading practices for clinical reviews, payor communication and clinical denial management to achieve financial outcomes.

**DC Planning / ToC:**
- DC plan initiated up admission
- Target LOS / DC date
- Identify safe DC LOC
- Determine readmission risk
- Align DC plan to payer auths

**Care Facilitation:**
- Daily huddle / outlier mgmt.
- Focus on DC checklist
- Facilitate flow thru LOCs
- Manage OBS per LOC / needs
- Identify EoL / complex needs

**Clinical Reviews:**
- Initial reviews – 24 hrs
- Concurrent reviews – 48 hrs
- 100% InterQual
- LOS / LOC
- Retro reviews

**Payer Communication:**
- 100% timely completion
- Automated / proactive
- Based on payor requirements
- Supported by central staff
- Documented / tracked outcomes

**Clinical Denials:**
- Admission LOC / concurrent clinical denial mgmt.
- Real-time tracking
- Retro clinical mgmt.
- Escalation to Physician Advisor
Focus Point #3
Denials Management – Measurement & Metrics
There is still a lack of Denial Rate Standardization of Measurement

Volume and percentage of denied insurance claims is still difficult to pinpoint

Variability exists regarding denial rate measurement

Payors are reluctant to share data

American Medical Association has published an annual report cards on denial rates since 2008

The wide variation in how often health insurers deny claims, and the reasons used to explain the denials,” says the AMA, “indicates a serious lack of standardization in the health insurance industry”
Key Performance Indicators to Measure Denials

Initial Denial Rate

Avoidable Denial Write-Off Rate

Recovery Rate
Comparative Benchmarking Analysis - Key Denial KPIs

Avoidable Insurance Denial Write-Offs (Historical View)

- Avoidable Write-Off Rate as % of Net Revenue
  - Top 10%: 0.9
  - Bottom 10%: 6%
  - Client A: 2%

Initial Insurance Denial Rate (Near Term View)

- Initial Denial Rate
  - Top 10%: 5.0%
  - Bottom 10%: 10%
  - Client A: 8%

HFMA
Focus Point #4
Denials Management – Using Big Data
Big Data and Healthcare Analytics

I combined a DNA test kit with big data to predict a person's future health issues.

That depressing knowledge caused every member of the test group to make risky lifestyle choices. Now half of them are dead.

At the risk of bragging, that's exactly what my model predicted.
Vignettes:
Denial Identification and Prevention

- Prior Authorization Denials
- Timely Filing Related Denials
- Coding Denials
Closer Look at Prior Authorization Denials

Key Point: Dashboards highlight key areas for analysis and investigation

**Navigation:** Dashboards > Category > Prior Auth

**Action:** Identify top Prior Auth denial scenarios by filtering for top denied payer
- CO197: $220k
- CO165: $62.7k

Next Step: Identify specific actionable patterns via Insights
Insights on Prior Authorization Denials

Key Point: Algorithm pattern insights focus on specific patterns that drive action

Navigation: Insights > Monthly > Prior Auth

Action: Select month and Prior Auth category, filter for CO197 reason code

Next Step: Choose specific actionable patterns via Insights, distribute actions

In one month, $32k in Prior Auth denials from Quality Healthcare came from one division and one group
Denials: Prior Authorizations

Case Example - Midwest U.S. Based Healthcare Provider

- Business process redesign of Financial Clearance Processes and use of Denial Data

Business Challenge

- Obtaining payor authorization for certain services prior to service to be executed following 4 different processes
- Errors related to completeness and timeliness of action required between areas were @ 12%
- The manual turnaround time took 2 business days including creation of record in one system and updating information in billing system

Value Delivered

- The number of manual steps were reduced to 2
- After redesign of processes and deploying analytic capabilities to pinpoint potential issues near real time, the error rate decreased to 2% within three months post implementation
- The turnaround time for entire automated process were decreased by 24 hours

- 83% Reduction in initial insurance denials without an auth
- 50% Reduction of time to obtain clinical review and notify payor to obtain authorization
Integration between Care Management and Revenue Cycle

**Three (3) key drivers** to reduce the recurrence of denials related to clinical reasons (e.g. medical necessity/level of care, timely reviews, non-covered services):

- Timeliness of action for appropriate statusing
- Completion of clinical reviews and
- Payor notification
Workflow Optimization

Design processes to ensure expedited resolution of items

Enable supporting technology to drive workflow to better manage handoffs between clinical, care management, and revenue cycle staff

How?

Rules-based exception list that triggers accounts requiring action/review

Utilize tools leveraging the system to facilitate communication between clinical, revenue, and care management staff
Vignettes: Denial Identification and Prevention

- Prior Authorization Denials
- **Timing Filing Related Denials**
- Coding Denials
Denial Write-offs due to Untimely Action still exist today

Untimely Filing Denial Write Offs by FC

<table>
<thead>
<tr>
<th>Plan</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$(30)</td>
</tr>
<tr>
<td>Medicare</td>
<td>$(25)</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>$(20)</td>
</tr>
<tr>
<td>Commercial Mgd</td>
<td>$(15)</td>
</tr>
<tr>
<td></td>
<td>$(10)</td>
</tr>
<tr>
<td></td>
<td>$(5)</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

$ (negative sign) for Medicaid indicates the largest loss.
Advanced analytics and visualizations provide users with immediate insights into root cause factors and patterns within denied claims.
Deeper Look into Timely Denials provides Insight into Problem Areas

<table>
<thead>
<tr>
<th>Category</th>
<th># of Months</th>
<th>Denied $ for Category</th>
<th>This Category % of All Denied $</th>
<th>This Category Denied % of All Billed $</th>
<th>Avg Denied $ per Month</th>
<th>Min Month Denied $</th>
<th>Max Month Denied $</th>
<th>Denied Claims for Category</th>
<th>This Category % of All Denied Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Filing</td>
<td>12</td>
<td>$3.53M</td>
<td>6.0%</td>
<td>0.8%</td>
<td>$286.7K</td>
<td>$195.7K</td>
<td>$495.3K</td>
<td>9.39K</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Top 10 Scenarios (Denied Amount) for this Category

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Denied $ for Scenario</th>
<th>% All Denied $ in Category</th>
<th>Denied Claims</th>
<th>% of All Denied Claims in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO29</td>
<td>$1.64M</td>
<td>46.5%</td>
<td>4.76K</td>
<td>50.7%</td>
</tr>
<tr>
<td>CO29,N30</td>
<td>$495.2K</td>
<td>14.0%</td>
<td>1.62K</td>
<td>17.3%</td>
</tr>
<tr>
<td>CO29,N21</td>
<td>$211.4K</td>
<td>6.0%</td>
<td>334</td>
<td>3.6%</td>
</tr>
<tr>
<td>CO29,CO45,N59,N45</td>
<td>$183.9K</td>
<td>5.2%</td>
<td>673</td>
<td>7.2%</td>
</tr>
<tr>
<td>OA29</td>
<td>$122.7K</td>
<td>3.5%</td>
<td>65</td>
<td>0.7%</td>
</tr>
<tr>
<td>CO45,CO29</td>
<td>$90.68K</td>
<td>2.6%</td>
<td>265</td>
<td>2.8%</td>
</tr>
<tr>
<td>CO29,CO45,N30</td>
<td>$88.59K</td>
<td>2.5%</td>
<td>274</td>
<td>2.9%</td>
</tr>
<tr>
<td>CO29,CO45,N45</td>
<td>$75.09K</td>
<td>2.1%</td>
<td>315</td>
<td>3.4%</td>
</tr>
<tr>
<td>CO29,CO45,N59,N45,CO29,CO96,CO45,N59,M86,N45</td>
<td>$54.03K</td>
<td>1.5%</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>CO29,CO23,CO22,N598,N30</td>
<td>$44.8K</td>
<td>1.3%</td>
<td>90</td>
<td>1.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$3M</td>
<td>85.2%</td>
<td>8.4K</td>
<td>89.5%</td>
</tr>
</tbody>
</table>

**CO29 (CARC)** The time limit for filing has expired  
**N30 (RARC)** Patient ineligible for this service
**Process Breakdowns are Major Factor driving Untimely Denials**

<table>
<thead>
<tr>
<th>Prior to Service</th>
<th>Time of Service</th>
<th>Time of Service / Post Service</th>
<th>Post Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Access</strong></td>
<td><strong>Care Management</strong></td>
<td><strong>Service Documentation/Coding/Revenue Integrity</strong></td>
<td><strong>Billing &amp; Collections</strong></td>
</tr>
<tr>
<td>− No Notification/No Pre-Authorization</td>
<td>− Denied Days for Inpatient Setting</td>
<td>− Incorrect Coding (i.e. ICD-10, Diagnosis, Procedure Codes, and CPT/HCPCs)</td>
<td>− Untimely Filing (Primary, Secondary, Tertiary,</td>
</tr>
<tr>
<td>− Service is Non-Covered by Third Party Payor</td>
<td>− Lack of Authorization (Days, Level of Care/Acuity and Service)</td>
<td>− Unavailable Medical Record or Documentation</td>
<td>− Untimely Follow-up</td>
</tr>
<tr>
<td>− Patient Ineligible</td>
<td>− Lack of Medical Necessity</td>
<td>− Modifier Review</td>
<td>− Contract Setup Error (System Calculation Error/Incorrect C/A)</td>
</tr>
<tr>
<td>− Benefits Exhausted</td>
<td></td>
<td>− Incomplete Clinical Documentation</td>
<td>− Insurance Interest Refund Untimely</td>
</tr>
<tr>
<td>− Incomplete Capture of or Incorrect Registration /Demographic related information</td>
<td></td>
<td>− Clinical Documentation Submission Untimely</td>
<td>− Unbilled Claim</td>
</tr>
<tr>
<td>− Lack of Medicare ABN</td>
<td></td>
<td>− Late Charge Submission</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Missing Codes for Encounter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Mismapped Charges</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Unbillable/Non-billable Charges</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**... Undesirable Outcomes**

Increase in Initial Insurance Denials and Avoidable Denial Write Offs
With Real-time Eligibility tools, Eligibility Denials less of a problem yet still occur

<table>
<thead>
<tr>
<th>Category</th>
<th># of Months</th>
<th>Denied $ for Category</th>
<th>This Category % of All Denied $</th>
<th>This Category Denied % of All Billed $</th>
<th>Avg Denied $ per Month</th>
<th>Min Month Denied $</th>
<th>Max Month Denied $</th>
<th>Denied Claims for Category</th>
<th>This Category % of All Denied Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>12</td>
<td>$6.33M</td>
<td>10.8%</td>
<td>1.4%</td>
<td>$479.3K</td>
<td>$0</td>
<td>$920.5K</td>
<td>21.67K</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Top 10 Scenarios (Denied Amount) for this Category

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Denied $ for Scenario</th>
<th>% All Denied $ in Category</th>
<th>Denied Claims</th>
<th>% of All Denied Claims in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO22,CO45,MA04,N45</td>
<td>$870.2K</td>
<td>13.8%</td>
<td>3.4K</td>
<td>15.7%</td>
</tr>
<tr>
<td>OA109</td>
<td>$854.1K</td>
<td>13.5%</td>
<td>3.33K</td>
<td>15.4%</td>
</tr>
<tr>
<td>CO31,N30</td>
<td>$494.5K</td>
<td>7.8%</td>
<td>1.56K</td>
<td>7.2%</td>
</tr>
<tr>
<td>CO27,N30</td>
<td>$479.4K</td>
<td>7.6%</td>
<td>1.66K</td>
<td>7.7%</td>
</tr>
<tr>
<td>CO22</td>
<td>$463.9K</td>
<td>7.3%</td>
<td>1.37K</td>
<td>6.3%</td>
</tr>
<tr>
<td>CO140,MA61</td>
<td>$401.3K</td>
<td>6.3%</td>
<td>1.02K</td>
<td>4.7%</td>
</tr>
<tr>
<td>CO177</td>
<td>$352.4K</td>
<td>5.6%</td>
<td>1.11K</td>
<td>5.1%</td>
</tr>
<tr>
<td>CO22,CO45,OA23,MA04,N419,N45</td>
<td>$289.2K</td>
<td>4.6%</td>
<td>1.01K</td>
<td>4.7%</td>
</tr>
<tr>
<td>CO22,MA04</td>
<td>$173.3K</td>
<td>2.7%</td>
<td>56K</td>
<td>2.6%</td>
</tr>
<tr>
<td>CO31</td>
<td>$118.0K</td>
<td>1.9%</td>
<td>454</td>
<td>2.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$4.50M</td>
<td>71.1%</td>
<td>15.49K</td>
<td>71.5%</td>
</tr>
</tbody>
</table>

**CO22 (CARC):** Coordination of Benefits (COB)
**N45 (RARC):** Pymt based on authorized amt
**MA04 (RARC):** Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible
**CO31 (CARC):** Patient cannot be identified as our insured
**N30(RARC):** Patient ineligible for this service
Key Steps to Improve Workflow and Enable Technology

• Eliminate redundant work and streamline processes
• Standardization of processes to better leverage staff, enhance process efficiencies and outcomes
• Optimize EHR/RCM system technology to support workflow
• Leverage bolt-on technology to address gaps in system functionality and drive near real-time data to empower staff in their decision making to resolve issue and complete work
Accountability and Training

• Support training and skill development
• Training is critical to improved outcomes and sustainability
• Monitoring / sharing real-time metrics to drive results and improve compliance
• Communications of outcomes will enhance accountability
Vignettes:
Denial Identification and Prevention

- Prior Authorization Denials
- Timely Filing Related Denials
- Coding Denials
# From Coding Denial Dashboard

## Key Point: Dashboards highlight key areas for analysis and investigation

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>This Category</th>
<th>All Categories</th>
<th>Category % of All Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td># OF MONTHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>THIS CATEGORY DENIED AMOUNT</td>
<td>ALL CATEGORIES DENIED AMOUNT</td>
<td>THIS CATEGORY DENIED AMOUNT % OF A...</td>
</tr>
<tr>
<td></td>
<td>$6.04M</td>
<td>$58.6M</td>
<td>10.3%</td>
</tr>
<tr>
<td>Denied Claims</td>
<td>13.18K</td>
<td>All Denied Claims</td>
<td>174.6K</td>
</tr>
<tr>
<td></td>
<td>Denied Claims % of All Claims</td>
<td>Denied Claims % of All Denied Claims</td>
<td>7.54%</td>
</tr>
<tr>
<td>This Category % of Totals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>THIS CATEGORY DENIED AMOUNT % OF TOTAL BILLED AMOUNT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.30%</td>
<td>TOTAL DENIED AMOUNT % OF TOTAL BILLED AMOUNT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This Category Denied Claims % of All Claims</td>
<td>Total Denied Claims % of All Claims</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>12.62%</td>
<td></td>
</tr>
</tbody>
</table>

Top 10 Payers (Total Billed Amount) for this Category
Insights to Coding Denial Data

Details provided on CARC and RARCs combination allows you to look at which areas require addressing more timely.

Key Point: Algorithm pattern insights focus on specific patterns that drive action.

<table>
<thead>
<tr>
<th>Category</th>
<th># of Months</th>
<th>Denied $ for Category</th>
<th>This Category % of All Denied $</th>
<th>This Category % of All Billed $</th>
<th>Avg Denied $ per Month</th>
<th>Min Month Denied $</th>
<th>Max Month Denied $</th>
<th>Denied Claims for Category</th>
<th>This Category % of All Denied Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding</td>
<td>12</td>
<td>$6.04M</td>
<td>10.3%</td>
<td>1.3%</td>
<td>$450.4K</td>
<td>$4.50K</td>
<td>$3M</td>
<td>13.18K</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

**Top 10 Scenarios (Denied Amount) for this Category**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Denied $ for Scenario</th>
<th>% All Denied $ in Category</th>
<th>Denied Claims</th>
<th>% of All Denied Claims in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO4,N657,N517</td>
<td>$1.19M</td>
<td>19.7%</td>
<td>3.32K</td>
<td>25.2%</td>
</tr>
<tr>
<td>CO252</td>
<td>$468.3K</td>
<td>7.8%</td>
<td>517</td>
<td>3.9%</td>
</tr>
<tr>
<td>CO252,29</td>
<td>$939.3K</td>
<td>5.6%</td>
<td>15</td>
<td>0.1%</td>
</tr>
<tr>
<td>CO16,N290</td>
<td>$337.0K</td>
<td>5.6%</td>
<td>931</td>
<td>7.1%</td>
</tr>
<tr>
<td>CO4,N657</td>
<td>$250.4K</td>
<td>4.1%</td>
<td>513</td>
<td>3.9%</td>
</tr>
<tr>
<td>CO252,N706</td>
<td>$187.5K</td>
<td>3.1%</td>
<td>105</td>
<td>0.8%</td>
</tr>
<tr>
<td>CO16,N4</td>
<td>$112.8K</td>
<td>1.9%</td>
<td>375</td>
<td>2.8%</td>
</tr>
<tr>
<td>CO4</td>
<td>$101.3K</td>
<td>1.7%</td>
<td>276</td>
<td>2.1%</td>
</tr>
<tr>
<td>CO181</td>
<td>$98.05K</td>
<td>1.6%</td>
<td>265</td>
<td>2.0%</td>
</tr>
<tr>
<td>CO251,N307</td>
<td>$93.22K</td>
<td>1.5%</td>
<td>215</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

**CO4 (CARC):** The procedure code is inconsistent with the modifier used or a required modifier is missing.

**N290 (RARC):** Missing/incomplete/invalid rendering provider primary identifier.

**N657(RARC):** This should be billed with the appropriate code for these services.
Post ICD 10 Era & Denial Rate

Denial rate data for more than 262 million claims processed between October 1, 2015 and February 15, 2016

- Of the $810 billion in claims processed just **1.6%** have been denied

- Percentage of claim dollars that were initially denied for ICD-impacted denial categories in relation to dollars billed on remitted claims

- Denial Categories measured included Authorization/Pre-Certification, Medical Coding, Medical Necessity, and Untimely Filing

- No change in denial rate since November 2015 however recent data shows slight **uptick** since October 2016

Source: Relay Health Financial Management ncial Feb 29, 2016“
Summary

In order to control the on-going challenge of denied claims, a Health System must:

- Transition from “reactive” to “proactive”
- Standardize processes, metrics, tracking and accountability for denials
- Include multi-discipline perspectives in the evaluation and prevention of denials
- Use data to develop a “deep” understanding of root cause of denials
Questions
To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT64

URL: http://www.hfma.org/awc/evaluation.htm

Your comments are very important and enables us to bring you the highest quality programs!