Moving from Denials Management to Rejection Prevention

Botsford Health

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Agenda/Objectives

• Importance of Focusing on Rejection Prevention
• Botsford Journey
  – Introduction to Botsford
  – Denials Management Structure
  – Rejection Prevention Mindset Shift
• Best Practices in Approaching Rejection Prevention
In this new world, you have to be ready to climb because the low-hanging fruit is gone.

 ..........Or is it

“My apathy is my own worst enemy”
-Mumford and Sons
Denials Environment

- “We’ve seen the denials problem increasing…not really by leaps and bounds but more incrementally,” says Barry Franklin, Chief Financial Officer of Parma (Ohio) Community General Hospital. “It’s always a problem—when payments are short by $100 here and a $1,000 there, pretty soon you’re talking about real money.”

- 34.5% of respondents say the problem with getting paid on the first attempt by managed care carriers is getting worse

- “upward trend in denials across the board for the first time since 2008”

RAC Pause

- In early February memo from Chief Administrative Law Judge Nancy Griswold detailing a more than 460,000 appealed claims backlog and a suspension of assigning new ALJ hearing dates for the next two years.

- Over 100 lawmakers sent a letter to CMS requesting “swift reform” of the RAC audit program
  - Referenced a November 2012 Office of Inspector General report that found 72% of inpatient appeals that reach the third level of the Medicare appeals process are overturned in favor of the hospital.

- On February 19th, CMS announced a “pause” to RAC requests until new contractors are chosen.
The Case for Rejection Prevention

- Denial Benchmarks as a % of Gross Revenue:
  - US Hospital Average: 11%
  - Best Practice: 5%
- Cost to Collect per dollar
  - US Hospital Average: 2.76%
  - Best Practice: 1.5%

The Efficiency gained from moving from the US Hospital Average Gross Denial rate to the Best Practice can reduce a hospital’s cost to collect by .4%.

Rejection Prevention Defined

- 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.

- Rejection Prevention recognized that not all denials are preventable and provides a focused approach to ongoing management of those denials identified as unavoidable.
Rejection Prevention
Balanced Focus

How do most hospitals use their resources?

- Common Practices
  - UR responsible for retro clinical denials
  - Infrequent or inconsistent clinical resources involved in denial management
  - Billers responsible for denials
  - Denials sent back to front-end rev cycle departments to work
  - All denials initially reviewed by entry level billing/follow-up teams
“Until You Spread Your Wings, You’ll Have No Idea How far You Can Walk”:

A Short Story of Botsford Hospital’s Rambling Journey From Denial Management to Rejection Prevention

Botsford Healthcare

- Location: Farmington Hills, MI
- Hospital Beds: 360
- Gross Revenue: $515 Million
- Annual Visits:
  - Inpatient: 16,000
  - Emergency: 61,000
  - Outpatient: 110,000
- Laboratory:
  - Outpatient: 77,000
  - Outreach: 237,000
Botsford Healthcare “The Family”

Background
- Hospital Affiliates
- Botsford Clinics
- Botsford Outreach Laboratory
- Botsford Rehabilitation and Continuing Care Center (SNF)
- Community EMS
- Parastar EMS Ventures:
  - Hospital-EMS Joint Ventures
  - Municipality EMS Billing

The Triggering Event

January, 2012
- Botsford Hospital migrates to Paragon HIS
- This fully-integrated clinical-and-financial information system introduces us to
  - Unprecedented patient care management
  - Unexpected patient data dependencies
  - Gives the Revenue Cycle its first opportunity to really connect
    Access to Billing
    Clinicals to Financials
    Rejections to Sources
Implementation of Denials Management

“We will go anywhere as long as it’s forward…”

• Financial State December 2011
  – Gross AR Days: 51
  – Gross AR Aged Percentage Under 90 Days (Third-Party): 80%
  – Denial Write-Offs as Percentage of Gross Revenue: 1.35%

• We were stable but had Room to Grow
• The implementation of Paragon planted the seed for denials focus
Phase 1

Goal:
Send the denials back to the front-end through work queues

Theory:
If they have to fix their mistakes they will stop making them

• Process:
  – Identify key Data-Providing ("Front-End") departments
    ▪ OP Surgery and Endoscopy (Pre-Surgical Testing and OR Scheduling)
    ▪ OP Radiology (Diagnostic Imaging)
    ▪ HIM (Medical Records)
    ▪ Inpatient – Acute (Case Management)
    ▪ Inpatient – Rehabilitation and GeroPsych
• Build Front-End work queues and assign rejections back to Front-End resolution
  – Pre-Bill Creation: “Data-Deficient” queues
• Pre-Bill Transmission: “Edited-and-Deficient” queues
• Bill- Rejection:
  • “Payer Pre-Edited-and-Rejected” queues
  • “Payer Processed-and- Rejected” queues
  • Enforce timely corrections from Front-End
Phase 1 Outcomes

- (October, 2012) – Mixed Results and a Need to Upgrade
  - Gross AR Days: **51**
  - Gross AR Aged Percentage Under 90 Days (Third-Party): **89%**
  - Denial Write-Offs as Percentage of Gross Revenue: **0.60%**

- Our “First Try” Learning Gems for Front-End and Back-End Areas
  - Better AR Days with much lower denial write-offs
  - Early-stage development of common language
  - Natural, unanticipated, surprisingly-strong Front-End resistance and delays in supporting timely corrections
  - Clear need for Business Office (“Back End”) to better support timely corrections from Front-End

Phase 2 – Improvements on Denial Management Process

- Identify Back-End partners for Front-End
- Co-assign Front-End rejections work queues to Back-End partners
- Schedule periodic “Queue Review” meetings with Back-End and Front-End (First Weekly, Then Not Weekly)
- Physically pair Central Scheduling / Pre-Arrival teams with OR Scheduling / Pre-Surgery Testing teams
Phase 2 – Improvements on Denial Management Process

- Provide better Front-End support
- Add in-house IP Financial Counseling to support Case Management
- Decentralize Diagnostic Imaging check-in and move Financial Clearance to Diagnostic Imaging areas

Phase 2 Outcomes

- (October, 2012) – Mixed Results and a Need to Upgrade
  - Gross AR Days: 50
  - Gross AR Aged Percentage Under 90 Days (Third-Party): 78%
  - Denial Write-Offs as Percentage of Gross Revenue: 0.38%

- Our “Second Try” Learning Gems for Front-End and Back-End Areas
  - Better AR Days with (again) lower denial write-offs
  - Priceless creation of common language and shared purpose
  - Educational, illuminating “Cause-and-Effect” meetings
  - Improvements in Denial Management
  - Back-End / Front-End teams are denial lower write-offs
The Real “Second Try” Take-Away.....

We’re getting much better at fixing our mistakes, but we’re still fixing our mistakes.

The “Second-Try” Big Idea . . .
- We have key teams and team members identified . . .
- We have almost all of the unfiltered rejection data . . .
- We have good working Front-End / Back-End relationships . . .

Our Time Is Right to Move from Denial Management to Rejection Prevention!

“Change is only necessary if survival is mandatory.”
Phase 3 Rejection Prevention

Two-Track Approach

• Track 1: Organizing and evaluating the Rejection Data

• Track 2: Forming the Front-End / Back-End Rejection Prevention team

Phase 3 Rejection Prevention

• Track 1: Organizing the Rejection Data
  – Collecting complete data (Billed Vs Rejected - By counts and by dollars)
  – Organizing the rejection data (By payer, by counts, and by dollars)

• Goals of Data:
  – Understand true causes of rejections/denials
  – Determine which rejections are avoidable
  – Use Rejection Prevention Team to create a plan
Botsford Denials Stats

- Initial Denial Rate as a % of Gross Charges
  - Botsford Data: 16%
  - US Hospital Average: 11%
  - Best Practice: 5%

- Write-off Rate as a % of Gross Charges
  - Botsford Data: .38%
  - US Hospital Average: .18%

Data Sample

<table>
<thead>
<tr>
<th>Denial Reasons - Top 10</th>
<th>Accounts</th>
<th>Charges</th>
<th>% of Charges</th>
<th>Denied $</th>
<th>% of Total Denied</th>
<th>Recovered $</th>
<th>% Recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect processing information</td>
<td>770</td>
<td>$9,755,604</td>
<td>16%</td>
<td>$6,045,112</td>
<td>23%</td>
<td>$5,251,987</td>
<td>28%</td>
</tr>
<tr>
<td>Duplicate claim / service</td>
<td>1422</td>
<td>$13,634,517</td>
<td>22%</td>
<td>$5,211,648</td>
<td>20%</td>
<td>$4,803,571</td>
<td>26%</td>
</tr>
<tr>
<td>Information needed from patient / insured</td>
<td>339</td>
<td>$3,200,299</td>
<td>5%</td>
<td>$2,675,910</td>
<td>10%</td>
<td>$1,230,632</td>
<td>7%</td>
</tr>
<tr>
<td>Claim lacks information for adjudication</td>
<td>617</td>
<td>$4,560,782</td>
<td>7%</td>
<td>$1,785,420</td>
<td>7%</td>
<td>$1,711,193</td>
<td>9%</td>
</tr>
<tr>
<td>Cannot identity patient as insured</td>
<td>474</td>
<td>$1,876,171</td>
<td>3%</td>
<td>$1,237,978</td>
<td>5%</td>
<td>$477,154</td>
<td>3%</td>
</tr>
<tr>
<td>Submission / billing error</td>
<td>127</td>
<td>$2,166,302</td>
<td>4%</td>
<td>$1,053,960</td>
<td>4%</td>
<td>$884,044</td>
<td>5%</td>
</tr>
<tr>
<td>Service not covered</td>
<td>256</td>
<td>$1,651,858</td>
<td>3%</td>
<td>$876,702</td>
<td>3%</td>
<td>$805,830</td>
<td>4%</td>
</tr>
<tr>
<td>No authorization</td>
<td>84</td>
<td>$1,409,087</td>
<td>2%</td>
<td>$723,682</td>
<td>3%</td>
<td>$553,914</td>
<td>3%</td>
</tr>
<tr>
<td>Authorization incorrect</td>
<td>127</td>
<td>$1,252,651</td>
<td>2%</td>
<td>$674,920</td>
<td>3%</td>
<td>$421,264</td>
<td>2%</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>219</td>
<td>$994,479</td>
<td>2%</td>
<td>$431,500</td>
<td>2%</td>
<td>$390,348</td>
<td>2%</td>
</tr>
</tbody>
</table>
### Preventable Rejections

<table>
<thead>
<tr>
<th>Reason</th>
<th>Denied Amount</th>
<th>Recovered</th>
<th>Sample Preventable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization incorrect</td>
<td>$674,920</td>
<td>$421,264</td>
<td>100%</td>
</tr>
<tr>
<td>Cannot ID patient as insured</td>
<td>$1,237,978</td>
<td>$447,154</td>
<td>90%</td>
</tr>
<tr>
<td>COB</td>
<td>$431,500</td>
<td>$390,348</td>
<td>90%</td>
</tr>
<tr>
<td>Claim lacks necessary information</td>
<td>$1,785,420</td>
<td>$1,711,193</td>
<td>80%</td>
</tr>
</tbody>
</table>

- Prior Authorization Root Cause
  - Medicaid Eligibility Enrollment Process
  - Non-entry of Authorization number on claim form

### Phase 3 Rejection Prevention

- Track 2: Forming the Rejection Prevention Team (Botsford Rejection Improvement Team)
  - Starting with the existing team
  - Business Office
  - Patient Access
  - OP Surgery and Endoscopy (Pre-Surgical Testing and OR Scheduling)
  - OP Radiology (Diagnostic Imaging)
  - HIM (Medical Records)
  - Inpatient – Acute (Case Management)
  - Inpatient – Rehabilitation and GeroPsych
Best Practices in Prevention

- Structure
  - Focused Denial Prevention Team
  - Focused Department Engagement with Data

- Data Collection
  - Root Cause
  - Data Analysis

Denials Prevention Team Composition

- Primary Focused Team of experts comprised of:
  - Separate Management in Business Office
  - Nurse Auditors
  - Accounts Receivable/Billing Specialists
  - Inpatient/Outpatient Coders
  - Clerical Support Specialists

- Secondary resources
  - Legal Support
  - Medical Director
Measurements

- HFMA MAP Keys
  - Initial Denial Rate – Zero Pay
  - Initial Denial Rate – Partial Pay
  - Denials Overturned by Appeal
  - Denial Write-offs as a Percent of Net Revenue
- Breakout Avoidable Denials vs Unavoidable
- Report and Trend Data
  - Total
  - By Payer
  - By Service Line

Root Cause Analysis

Requires:
- Insurance accurately identified
- Patients have appropriate coverage
- Services are authorized
- Patient understands financial liability

Requires:
- Contract Terms shared with Patient Finance
- Pharmacy
- Accurate EHR and clinical systems
- Department knowledge of charge rules

Requires:
- Accurate Patient Status
- Secured Verified Authorization

Requires:
- Accurate CDM
- Controlled process for billing supplies/Pharmacy
- Accurate ICD and clinical systems
- Department knowledge of charge rules

Requires:
- Focused payer specialists
- Focused Denial Management Specialists
- Process for identifying and reviewing underpayments

Requires:
- Identification of ability to pay
- Enrollment in funding programs
- Technology to ensure cost effective small balance collection
- Payment plan options
Questions..............................................