OUTSMART DENIALS

Strategies for a proactive plan

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1. Welcome
2. Market Challenges + Insights
3. 3 A's to Outsmarting Denials
4. Final Takeaway
5. Q&A

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Learning Objectives

3 A's to Outsmarting Denials

In this session, we will cover how to:

1. Automate front-to-back-end processes
2. Allocate denials for smart follow-up
3. Avoid write-offs across all channels

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Current State of Denials

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The average denial rate has increased 33% since 2016[1]

A problem worth solving

3 of 4

Respondents indicated reducing denials as their highest priority[1]

41%

of denials are caused by front-end issues[2]

5-15%

of the time claims are denied, resulting in billions of dollars of delayed or lost revenue[1]

55%

Of registration/eligibility denials are avoidable but non-recoverable[2]

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[1] The State of Claims Survey 2022
[2] Denials Index 2022

Eligibility

22%

An improvement from 2021 but still the largest contributor to denials is registration/eligibility[1]

Data

16%

of denials are due to missing or invalid claim data[1]

Documentation

14%

of denials is due to medical documentation required – an increase from 2021[1]

Authorizations

13%

Authorizations/Pre-Certification account for the 4th largest contributor to denials[1]

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[1] Denials Index 2022

49.5%[1] of leaders allocate most of their denials related resources to working denials + submitting appeals

Leaders who allocate most of their denials related resources to denial prevention experience a **2.7%**[1] lower denial rate than those who do not

53%[2] of providers say denials are most often manually reviewed and assigned to a work queue while **10%**[1] say they don't even have a way to accurately filter or prioritize denials

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[1] HFMA Denials Study 2023
[2] State of claims

The 3 A's to Outsmarting Denials

Automate

Front-to-back-end processes

Allocate

Denials for smart follow-up

Avoid

write-offs across all channels

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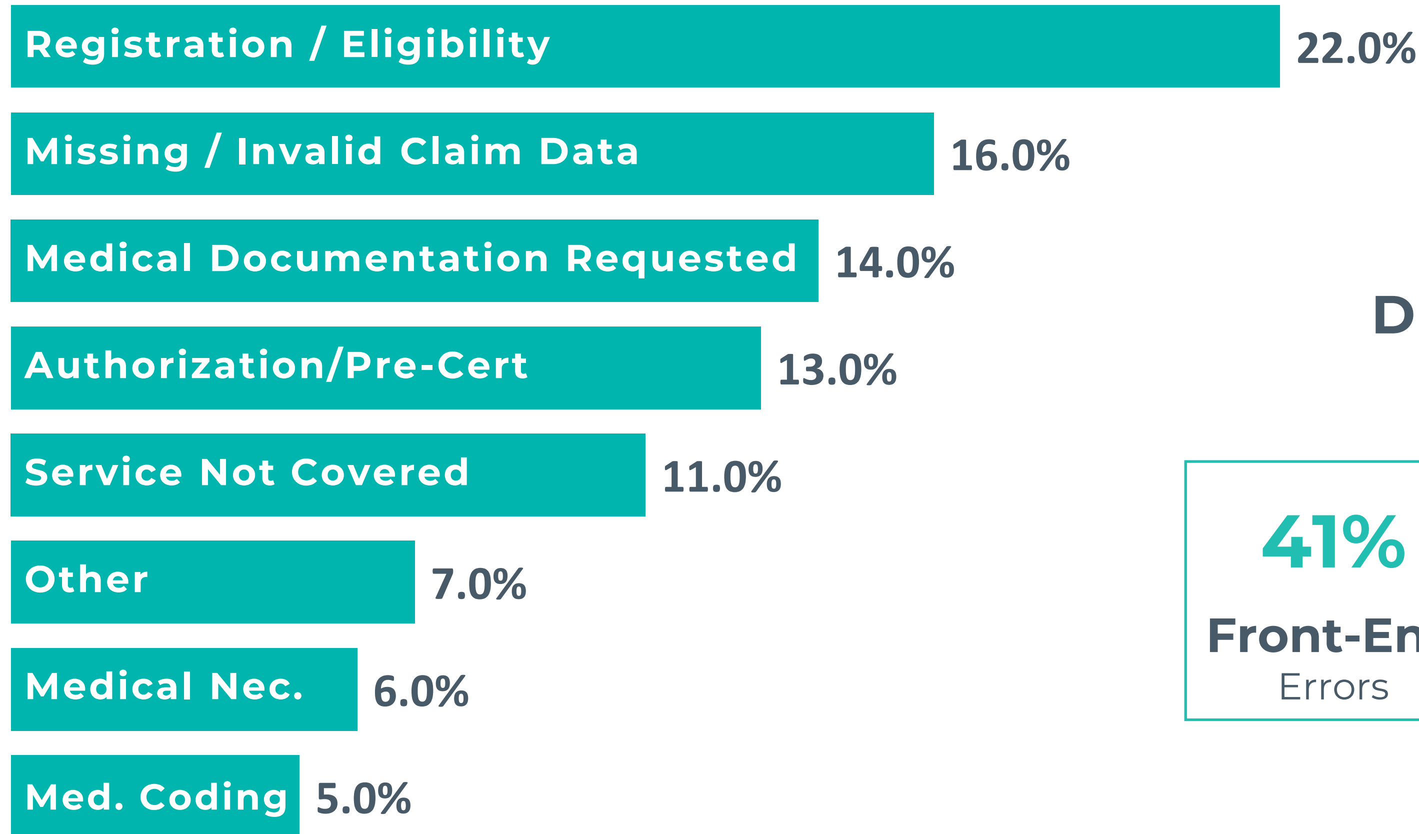
Automate

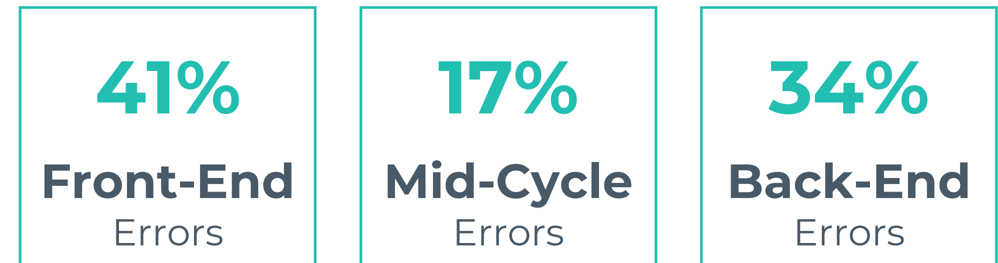
Front-to-back-end processes

AUTOMATE

More than half of denials are front-end related



Denial Breakdown by RCM Areas*



*Unknown Breakdown = 8%

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[1] Denials Index 2022

AUTOMATE

Questions to consider

- How much time is spent manually finding/confirming coverage?
- Do we have an opportunity to automate + streamline authorizations?
- What is our process to identify missing charges and DRG anomalies?
- Do we automate claim status checks based on specific payer performance?
- How does my staff identify + prioritize their denial work?
- Is my team manually creating and submitting appeal packages to payers?
- Is our payment posting/reconciliation process completely automated?

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Automation opportunities across the rev cycle

1 Eligibility Verification

Use of RPA to augment missing data from X12 in order to **return richer, more accurate benefit information** as well as identify potentially missing insurance coverage

2 Estimation of Patient Responsibility

Use of machine learning (AI) to identify payer adjudication rules and RPA to retrieve **real-time updates on patient financial responsibility and deliver truly accurate patient estimates**

3 Prior Authorizations

Use of machine learning to **identify upcoming services requiring authorization + RPA to initiate and follow-up on authorization requests**

4 Patient Payment Optimization

Use of predictive analytics to **provide tailored payment options** and **automated identification of charity** determination while delivering **personalized communications to drive self-service payments**

5 Revenue Capture

Use of machine learning to identify accounts with a high probability of **missing charges and DRG anomalies** to maximize revenue opportunities

6 Claim Status Checks

Predictive analytics to optimize when to **check status of claims**, use of **RPA to retrieve updated claims status** information, and AI to **normalize each payer's unique remark codes and auto-assign disposition codes**

7 Denial Management

Predictive analytics to **identify those denials most likely to be successfully appealed** in order to guide workflow

8 Payment Posting/Reconciliation

Automated **matching of claims to remits, posting of payer and patient payments**, including remit splitting and identification of missing payments as well as **reconciliation of all payments**

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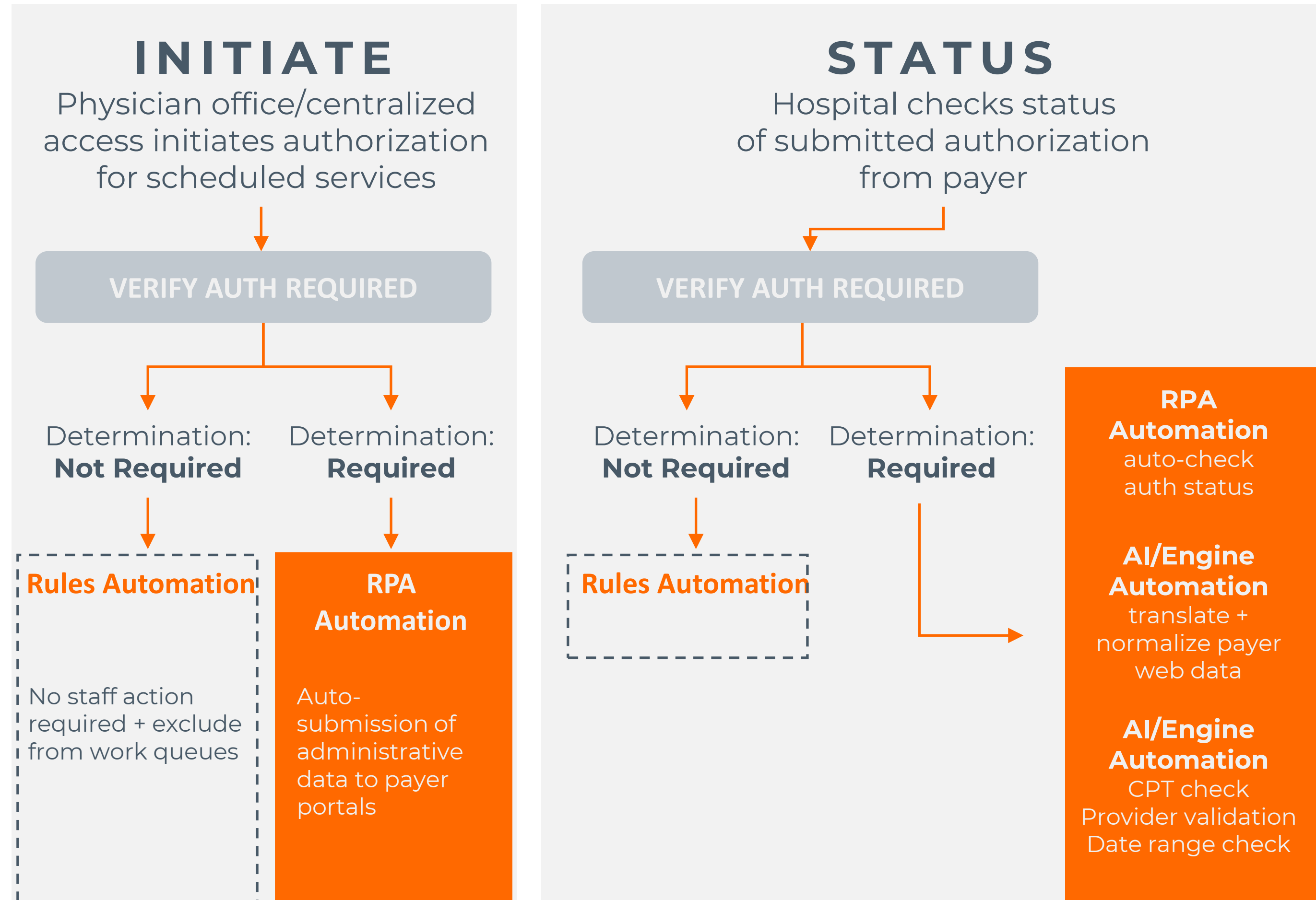
AUTOMATE

Automating prior authorizations at scale

- Leverage purpose-built automation to navigate payer-specific rules
- Continuous status monitoring enables staff focus and efficiency
- Exception-based workflows alert staff to act only if/when needed
- Reduce auth-related denials by effectively initiating, statusing and logging authorizations across the largest set of service lines and settings
- Utilize multiple data transfer methods, including RPA, HL7, APIs, EDI 278



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AUTOMATE

Intelligently automate status checks

- + Automate status checks + **intelligently route claims to the correct work queues**
- + Leverage multiple connections to retrieve the most **enriched claim data directly from payers**
- + Ensure **responses are normalized** and supports actionable follow-up
- + Leverage technology to provide automated statuses at the right time, **reducing unproductive touches** + shifting focus to cases requiring follow-up
- + Improve overall efficiency, resulting in **time and cost savings**

THE APPROACH

Curate
the most enriched status responses

Control
claim follow-up with proactive work queue routing

Capture
payments faster + forecast your AR

THE RESULTS

Accelerate cash flow

Save time + reallocate resources

Increase user productivity

Reduce overall A/R days

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AUTOMATE

Accelerate appeals + convert denials to payments

PAPERLESS APPEAL PACKAGE + SUBMISSION OPTIONS

Certified mail

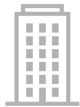
Print + mail

e-Fax

Payer portals

PRE-POPULATED, PAYER-SPECIFIC APPEAL TEMPLATES

Commercial payers


Government payers

Pre-filled fields

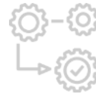
Attachments

TRACKING + REPORTING + CONTROL ACROSS ALL APPEALS

Transaction history

HIS/PM integration

Settings options


Workflow tracking

The value

- Maximize your investment
- Decrease write-offs
- Reduce cost to collect
- Eliminate appeal uncertainty
- Improve productivity + streamline workflows
- Increase realized revenue

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Allocate

Denials for smart follow-up

ALLOCATE

Flexible workflows to meet unique needs

Authorization

Invalid Coding

Missing Documentation

Eligibility

Medical Necessity

Coordination of Benefits

Allowed Maximum Benefit Met

Timely Filing

Out of Network

Secondary Claim Error

Duplicate

Attachment Needed

Level of Care

Add'l Info Required

Claim Error

Non-Covered Services

Control denial workflow dynamically + quickly across multiple parameters

- Create New Workgroup
- New Denial Tag
- Denial Closure Settings
- Appeal Settings
- General Denial Settings

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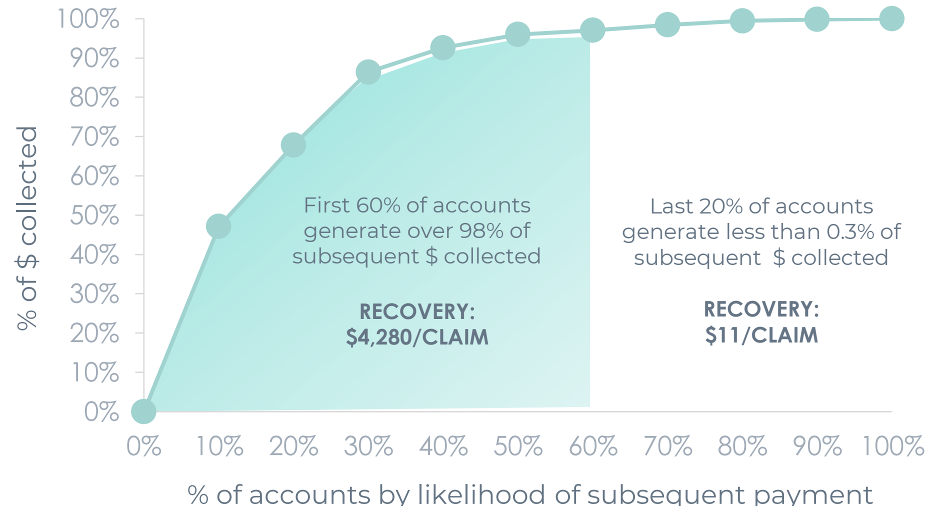
ALLOCATE

Accurately prioritize denials

- Identify workable denials via **predictive analytics identifying probability of payment**
- **Automatically route** those denials to appropriate team or work queue
- Leverage **900+ pre-populated payer-specific forms** to automatically generate the right appeals content on your behalf
- Provide real-time **one-click eligibility** verification
- **Automatically submit paperless appeals** packages directly to payer

The value of our predictive analytics:

- By analyzing massive sets of CARC/RARC patterns, it's possible to **predict the probability of additional payment** on a given denial
- This enables **prioritization based on payment**, rather than the typical approach of age or balance, saves time and produces better, faster results.



Automatically prioritizing the accounts to work

Automatically focus on only those that will be successful

Automatically complete the appeal form

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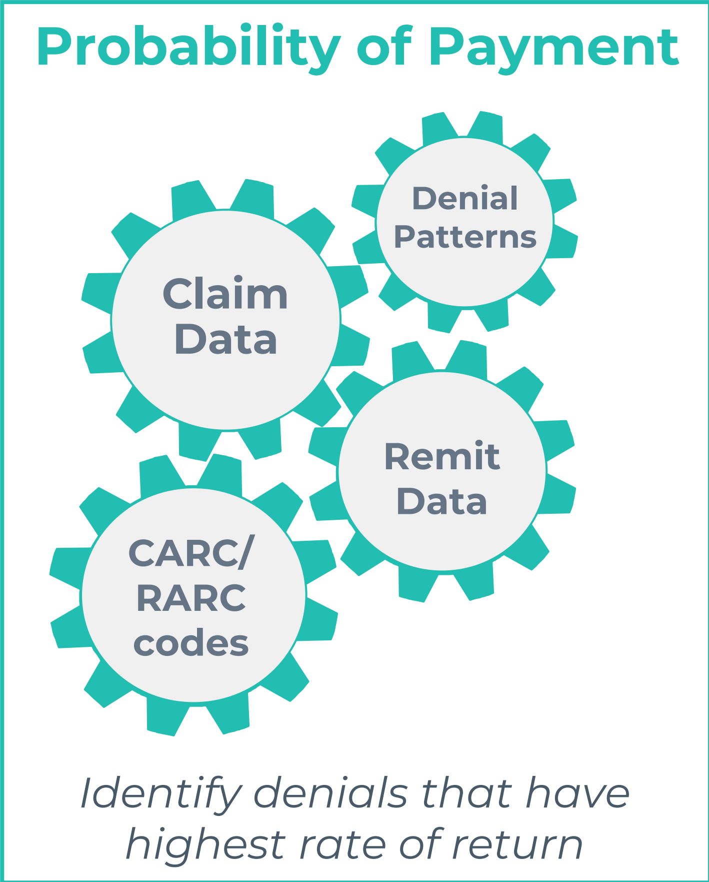
ALLOCATE

Leverage technology to prioritize denials



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Work Smarter
leverage innovative technology to improve staff efficiency while increasing recovered revenue

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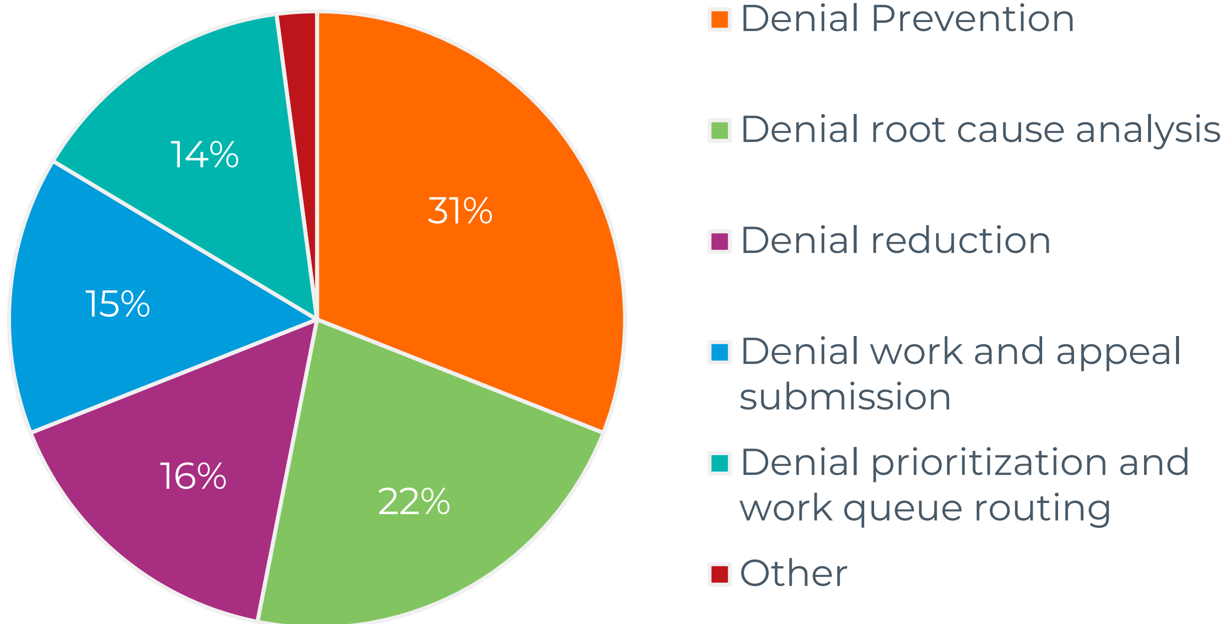
Avoid

Write-offs across all channels

AVOID

Denial prevention tops the priority list



While denial rates continue to rise:

Up **20%** with the trend expected to continue[2]

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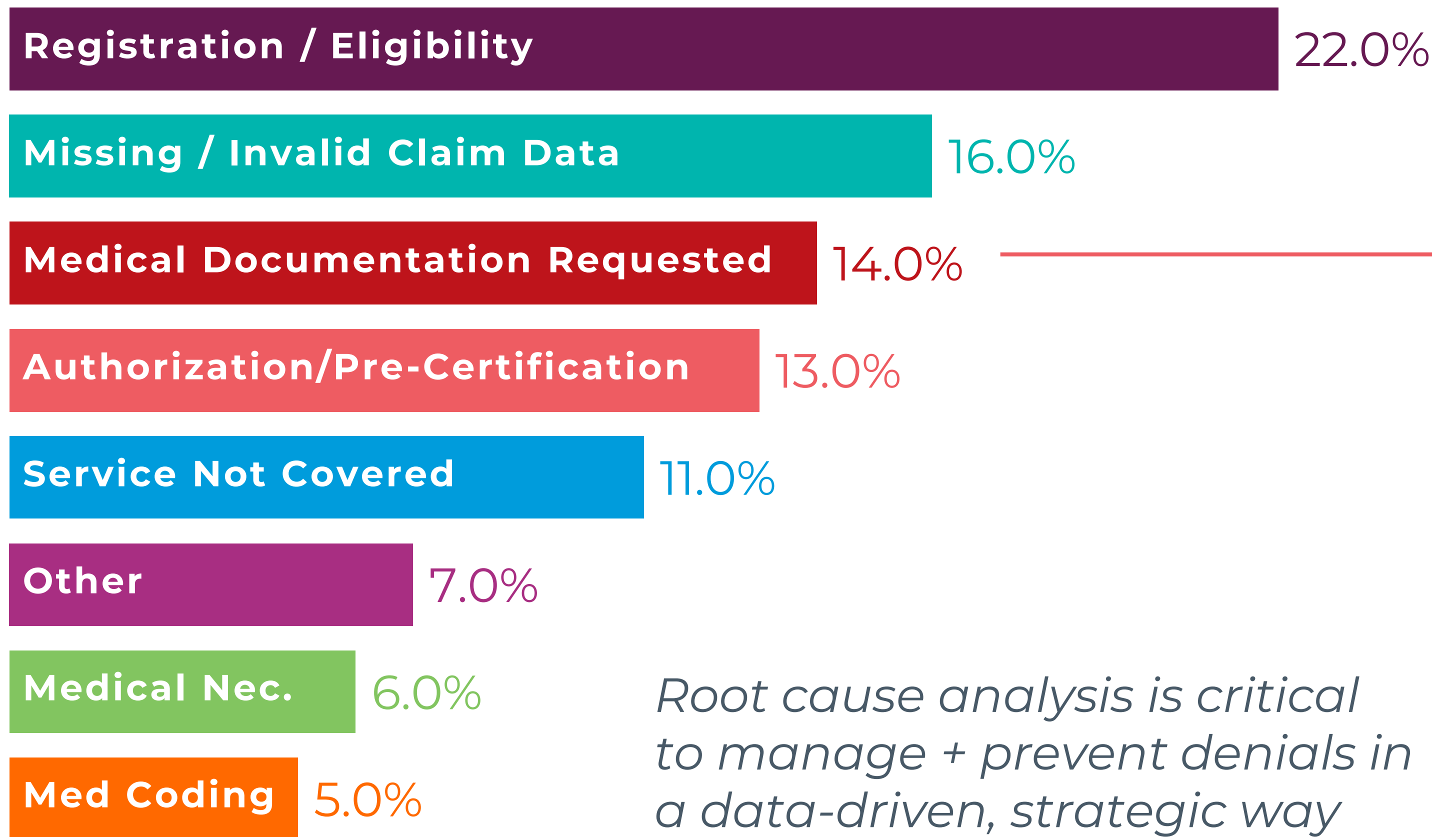
[1] HFMA Denials Study 2023
[2] Journal of the American Health Information Management Association, Claim Denials: A step-by-step approach to resolution (2022)

AVOID

Denial reason ≠ root cause



Sample Root Cause Issues

OON Provider	Registration Error	Allowed Max Benefit Met
Missing Provider Info	Secondary Claim Error	Invalid Coding
Order Change	Add-on Service	Recurring Encounters
ABN Not Signed	Experimenta l Procedure	Procedure Not Contracted
Payer Needs More Info	Medical Necessity	Missing/Insuff. Documentatio n
Missing/Insuff. Documentation	Unlisted Dx Code	Length of Stay
New User Training	Process Gap	New Technology
Retro Coverage	Primary Claim Delay	Delayed Appeal

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AVOID

Discover denial patterns through analytics

Root Cause Reason

Claims by Denial Reason

Dollars Denied / Adjusted

Claims Denied + Reworked

Avoidable Denial Write-Off Rate

Denial Overturn Rate

First Pass Clean Claim Rate

Payer Scorecard

Denied Procedures

Sample denial metrics

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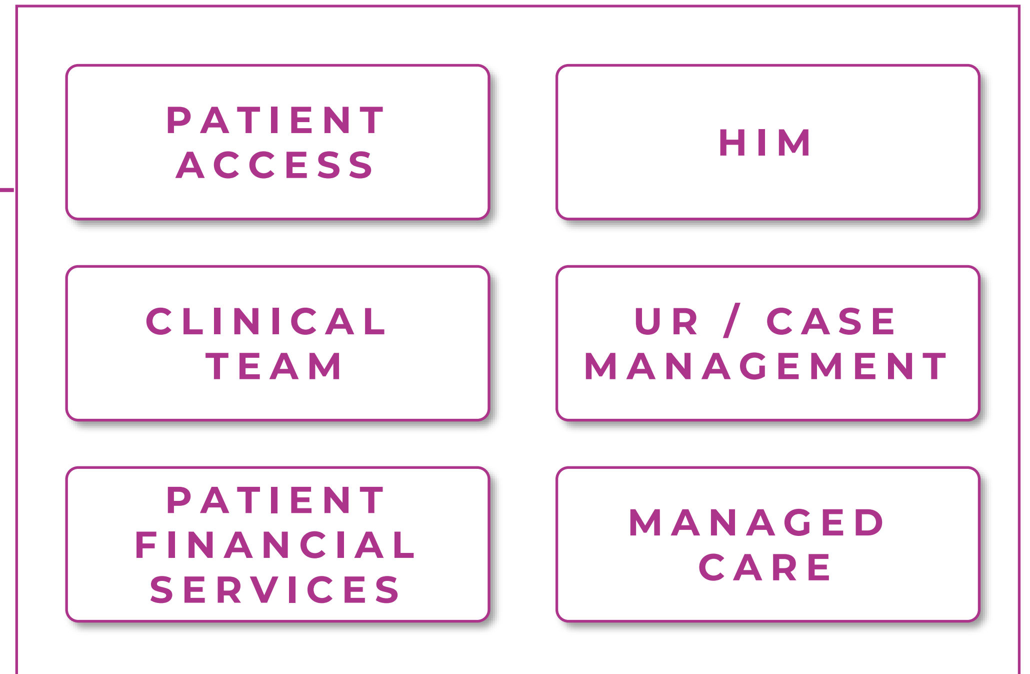
AVOID

Denials is an everyday problem, alignment is key

Key steps to establishing successful denials prevention strategy

1. Executive support + multi-disciplinary alignment
2. Establish expectations, ownership, cadence
3. Perform root cause analysis
4. Define + execute action plan
5. Track + measure improvement
6. Continuous refinement



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Q + A

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