Denials Prevention

The Pathway to Success

Meet Our Speakers

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Denials Rates Continue to Increase

A 2024 article published by the American Hospital Association noted:

Nearly **15% of all claims** submitted to private payers were initially **denied**, including many that had prior authorization approved.

Additionally, 15.7% of Medicare Advantage and 13.9% of commercial claims were initially denied.

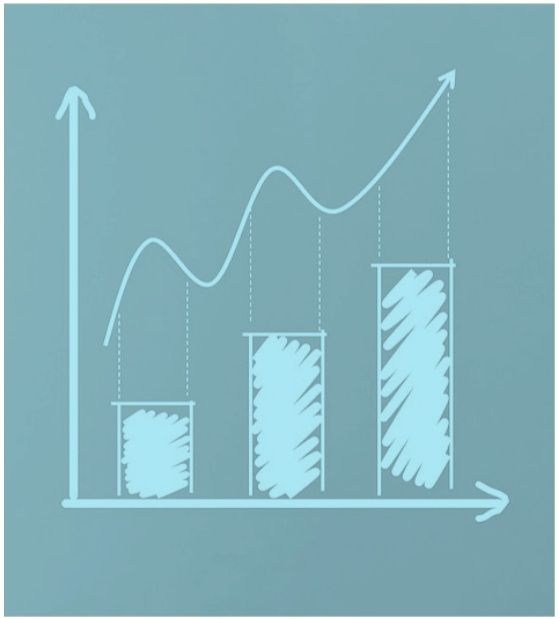
Of those denied claims, **54.3%** were eventually **overturned**, but only **after** multiple **rounds** of costly appeals.

Denied claims were more prevalent for higher-cost treatments with average denied charges of $14,000 or more.

In 2022, health systems spent an estimated **$19.7 billion** trying to overturn denied claims.

Increased Denials Equal Increased System Costs

Hospital and health system respondents that fought the denials did so at an average cost of **$43.84 per claim**



- Clinical labor adds an estimated **$13.29** to the adjudication cost per claim for a general inpatient stay and **$51.20** to the cost of inpatient surgery.
- Survey respondents needed an average of three rounds of appeal/review with insurers, with each cycle taking 45-60 days or more to complete, before payment was obtained.
- Delays in insurer reviews led to almost **14%** of all claims being **past due** for remittance. Leaving providers **unable** to **recoup** costs for up to **6 months post-service**.
- Current trends show this continues with insurers citing **staffing issues** as one **barrier to** timely appeal **review** completion.

Denials Strategy

What is your current denials strategy, including best practices and how you handle appeals and negotiate contracts?

Largest Denial Reasons

What are your largest denial reasons as an organization? And what is your team doing to combat these specific areas?

Poll Question

Scan the QR code with your phone to participate >>

What is your most common reason for denied claims?

Appeals Process

What is your process for appealing a claim based on the denial reason? Does your organization appeal every claim regardless of dollar value? If not, how do you determine what to pursue? Do you ever utilize external counsel for this?

Poll Question

Scan the QR code with your phone to participate >>

What is your largest denials management pain point?

Preventing Prior Authorization Denials

Does your organization have a strategy in place to prevent prior authorization denials?

Poll Question

Scan the QR code with your phone to participate >>

What would you do with more revenue from denials recoveries?

Root Cause Analysis and KPIs

What is your process for establishing the root cause of a denial and analytics around KPIs for denials?

Poll Question

Scan the QR code with your phone to participate >>

Who handles your denials management workflow?

Payor Issues and Escalations

How do you approach insurance companies with issues and what are your processes for getting resolution (contested denials – escalation process)?

Contract Management and Reimbursement Policies

How important are contract management and reimbursement policies in denials? And do you have any resources or thoughts on underpayments or variances?

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Why Are Denial Rates on the Rise?

Rising rates attributed to:

- Insufficient data analytics to flag issues in submissions (65%)
- Lack of automation in the claims and denials management process (64%)
- Inadequate staff training on claims submission and denial prevention (49%)

According to a 2024 benchmarking analysis, **denials** now **account** for **13%** of all claims, a jump from 11% reported in 2022. For an average-sized health system, this figure translates to 130,000 unpaid claims annually.

Operational inefficiencies and insufficient resources are primary barriers that hospitals need to overcome to better manage their revenue cycle.

Identifying the Root Cause of Denials

- Identify “what went wrong” What did the provider potentially do or miss to cause the denial?
- Review the feedback from the payer - this includes the claim adjustment reason code (CARC) and payer communication.
- Complete an analysis of the medical record, charges, and the billed claim for internal errors.
- Determine the actual root cause versus relying on the reason code(s).
- The root cause should be specific to the situation with an actionable recommendation to prevent recurrence.
- Example: Payer denied as “not deemed medical necessity by the payer.”
- Potential root causes:
  - Documentation did not support inpatient level of care
  - Service not deemed appropriate for the diagnosis
  - Lack of clinical submission to support the need for services rendered

Defining and Standardizing Root Cause

- Develop and define each root cause category with relatable examples:
  - 1st level – broad, typically assigned based on CARC/remark code
  - 2nd level – detailed, typically assigned based on review of all available information internally and from carrier
- Standardized, repeatable training of any associates who will be applying the root cause to a denial
- Define the specifics to ensure the categories are straightforward and easily applied
- Standardization allows for the most accurate comparisons between facilities and dates of service

Denial Root Cause Examples

Drill down Root Causes: **Medical Necessity**

	2021		2022	
Root Cause: Medical Necessity	**No. of Accts**	**Dollars Placed**	**No. of Accounts**	**Dollars Placed**
Not Medically Necessary	1,897	$10,035,328	267	$1,156,805
NCD/LCD	840	$6,498,104	97	$701,416
Level of Care	910	$1,786,621	206	$393,211
Experimental/Investigational	764	$2,325,821	82	$210,283
IP Criteria Not Met	5	$27,454	2	$33,810
All Other Medical Necessity	19	$66,990	0	$0
Grand Total	**4,435**	**$20,737,318**	**654**	**$2,495,525**

Denial Root Cause Examples

Drill down Root Causes: **Authorization**

	2021		2022	
Root Cause: Authorization	**No. of Accts**	**Dollars Placed**	**No. of Accounts**	**Dollars Placed**
Authorization Not Obtained	2,924	$10,761,998	463	$2,031,165
Client was informed No Precert Needed (NPN), is required	590	$5,622,782	123	$1,481,265
Payer Error	670	$6,049,206	161	$1,370,736
Authorization Coding Conflict	438	$4,161,989	91	$911,268
DOS Conflict	151	$972,642	43	$436,398
Partial Authorization Obtained	247	$1,253,940	46	$302,091
All Other Authorization	902	$6,586,571	187	$110,780
Grand Total	**6,122**	**$37,189,184**	**1,174**	**$8,287,260**

Putting the Information into Action

Identify Key stakeholders

Include a variety of parties from high level leaders with the ability and authority to effect change to front line staff who will put the plan into action.

Project management collaboration

Identify the “best practice” and steps to implement it in the workflow.

Set objectives with measurable outcomes for progress tracking and a goal for success.

Meet regularly with the key stakeholders and include ad hoc subject matter experts as needed.

Give front line staff a voice to avoid unrealistic expectations and avoid barriers.

Implement process changes as they are identified with targeted education regarding impact and expected outcomes.

Continue monitoring for sustained success and further opportunities.

IP Case Study

Facility– Case Study X123456789

Admission Detail

Invoice Number:

MRN:

Facility:

Claim DOS: 04/22/2024 – 05/06/2024

Inpatient Admission: 04/22/2024 (Monday)

Discharge: 05/06/2024 (Monday)

LOS: 14 days

Payor/Pre-Appeal Payment Details

Payor: UHC Medicare

Total Charges: $132,428.64

Paid Amount: $0.00

Underpaid Amount: $29,287.14

Clinical Summary

EMR: 84-year-old female with a past medical history significant for malignant neoplasm of the ascending colon. Presented on 04/22/2024 for a planned robotic laparoscopic large bowel resection due to bowel mass. Post operative complication of hypotension. She later developed distention, nausea, and vomiting and required nasogastric tube (NGT) to suction (LIWS). Imaging revealed a hernia at the laparoscopic port site with obstruction, and she underwent a diagnostic lap for repair on 04/29/2024. She continued with NGT to LIWS. Her diet was advanced on 05/02/2024 and NGT was clamped. She had return of bowel function on 05/04/2024. On 05/05/2024, she was advanced to soft diet and required electrolyte repletion. On 05/06/2024 she was discharged to a skilled nursing facility.

Auth/Denial Detail

Facility Auth Details

Authorization Facility Obtained:

- 04/18/2024: EPIC notes show prior authorization for IP Only procedure (CPT 44205-surgical laparoscopy that involves a partial colectomy with the removal of the terminal ileum and ileocolostomy) obtained under reference #A1234. No authorized bed days noted.
- During appeal review, UHC Medicare advised Revecore that the authorization was for outpatient, not inpatient. [Payer Error]

Case Management Documentation:

- 04/23/2024 1503: Clinical Review. "Per guidelines, CPT 44205 is an IP ONLY procedure... IP/IP... review complete."
- 05/06/2024 1127: Concurrent review, update sent, patient still in house.
- 05/07/2024 0801: DC Summary sent.

Criteria Used by Facility/Findings:

- CME Inpatient Only List
- MCG Bowel Surgery: Colectomy, with or without Ostomy, by Laparoscopy RRG.

Payor Denial Details

Service Denied by Payor: Inpatient Admission

Denied Dates: All days

Root Cause Analysis and Suggestions

Revecore Findings:

- Authorization for IP only procedure obtained prior to admission. The number of authorized IP days was not documented. [Red Flag]
- Patient had post-operative complications and required a 2-week IP hospital stay.
- Concurrent clinical review was completed on 05/06/2024 after reviewer noted that patient was still admitted.

Improvement Points:

- Significant time lag between initial clinical review and concurrent clinical review.
- Inpatient authorization with IP only procedure, but no documentation of any approved days.

Suggestions:

- Education to UM staff to verify if approved IP days are documented at the time of initial review or acknowledgment of the admission.
- For Elective and/or IP Only procedures: If no authorized days are documented, follow UM process for communication with prior authorization team, MD office, payer, or other appropriate party to verify if authorization was for IP or OP and if/when clinical reviews are required.
- Initial and concurrent clinical review of IP Only procedure cases if they pass the expected length of stay. Notify the payer and submit clinical review if not already initiated.

Appeal/Outcome

Appealed: Yes

Date Appealed: 07/09/2024

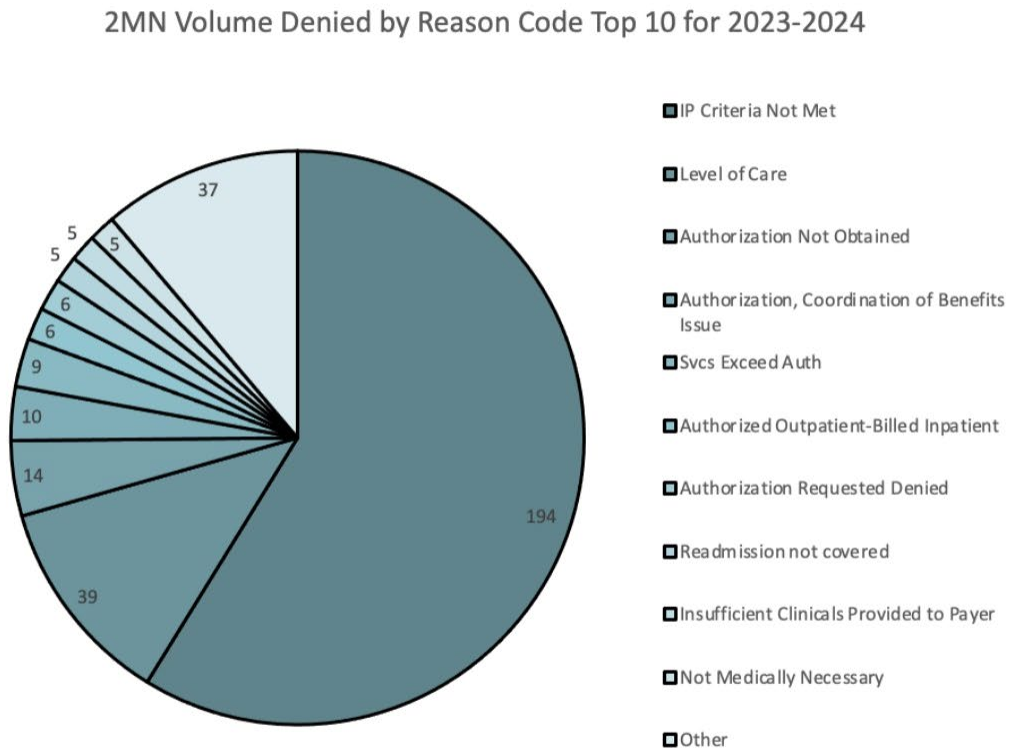
Appeal Outcome: Overturned

Date of Appeal Outcome: 07/22/2024

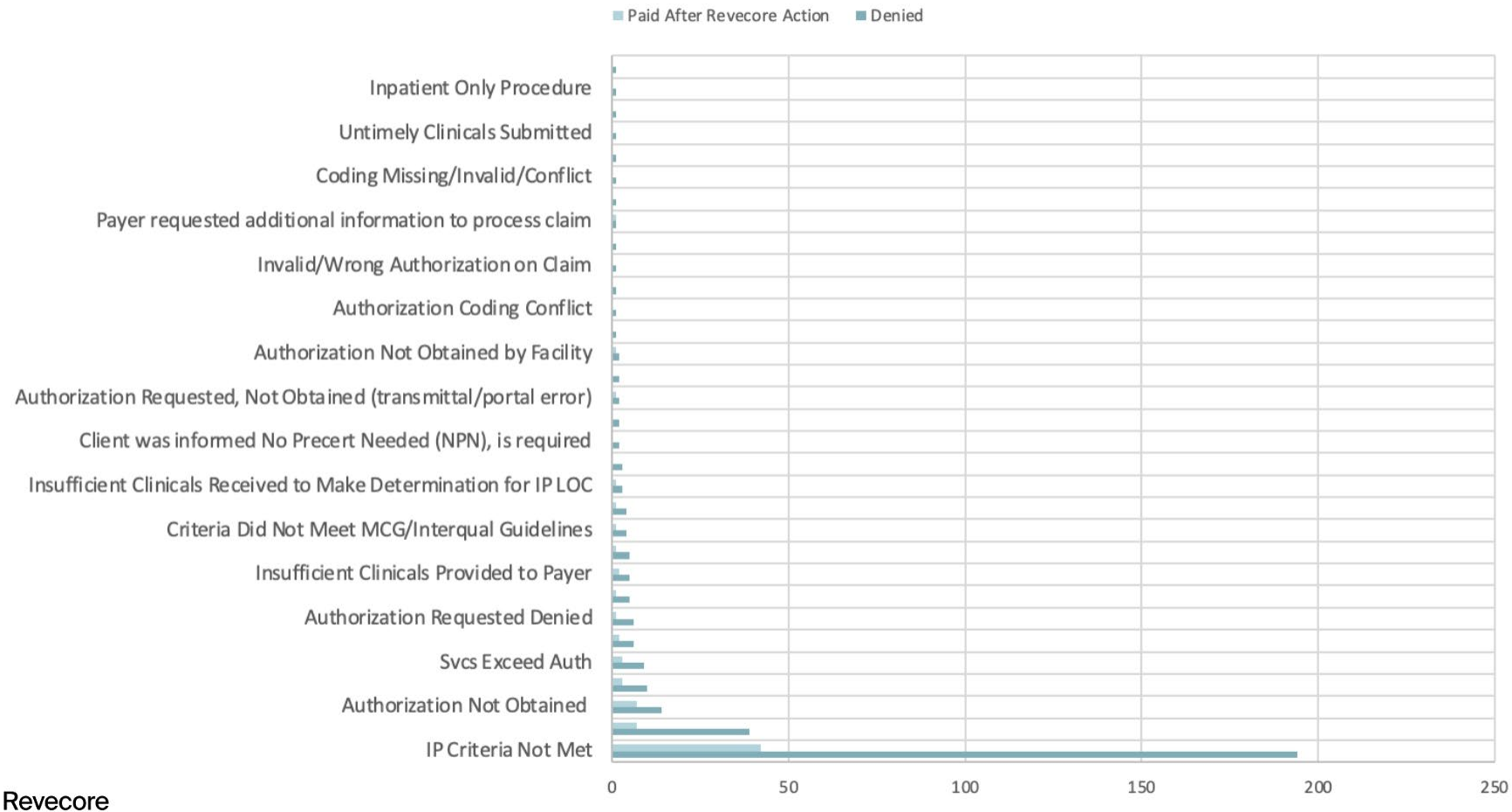
Post Appeal Payment: $28,780.19

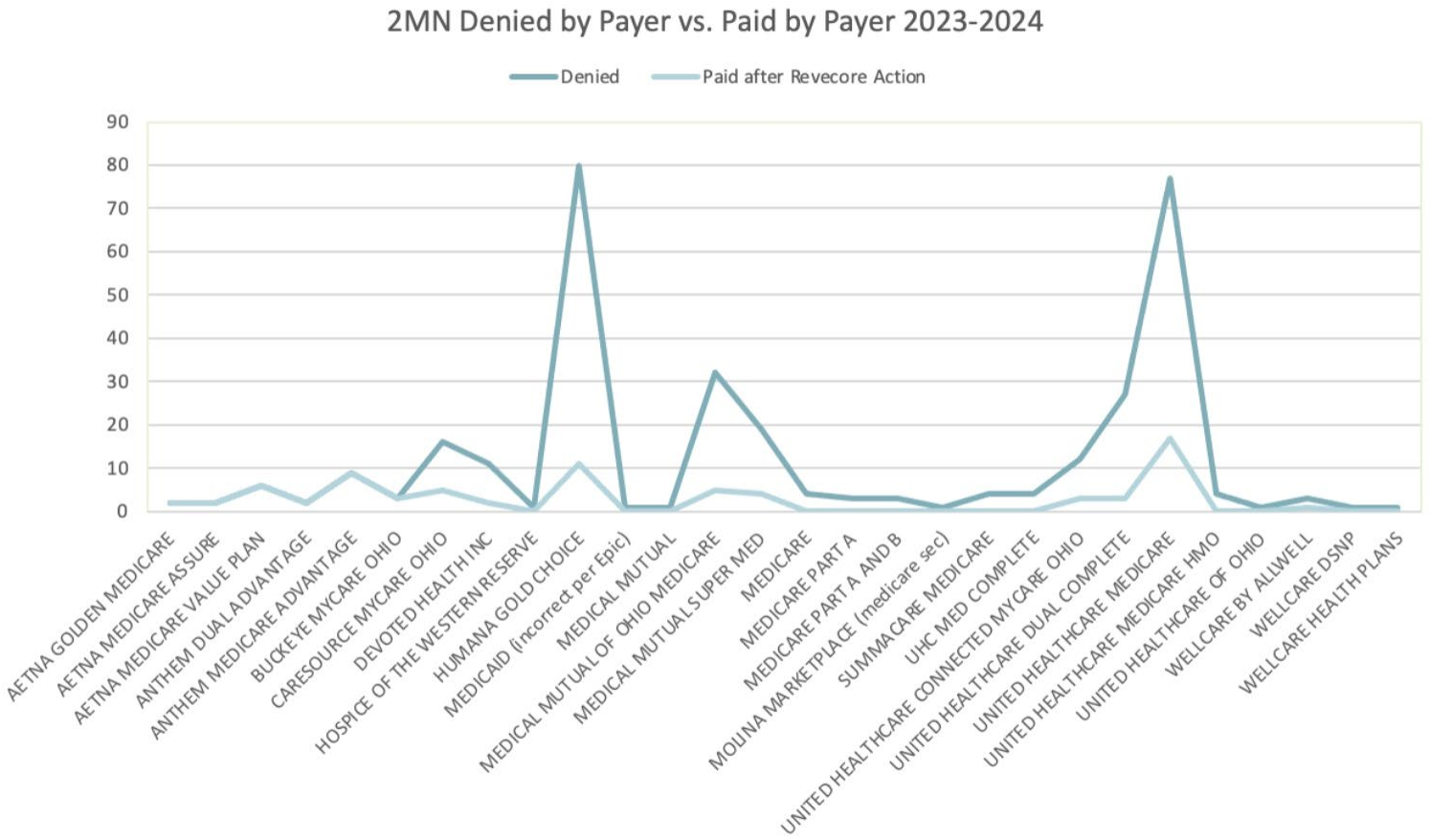
Appeal Impact Statement: Per CMS guidance, a Medicare Advantage plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when the inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2)).


2MN Volume Denied by Reason Code
2023-2024
Inpatient Only Procedure
Untimely Clinicals Submitted
Coding Missing/Invalid/Conflict
Payer requested additional...
Invalid/Wrong Authorization on...
Authorization Coding Conflict
Authorization Not Obtained by...
Authorization Requested, Not...
Client was informed No Precert...
Insufficient Clinicals Received to...
Criteria Did Not Meet...
Insufficient Clinicals Provided to...
Authorization Requested Denied
Svcs Exceed Auth
Authorization Not Obtained
IP Criteria Not Met
0
50
100
150
200
250


2MN Volume Denied by Reason Code Top 10 for 2023-2024
37
5
5
5
6
6
9
10
14
39
194
IP Criteria Not Met
Level of Care
Authorization Not Obtained
Authorization, Coordination of Benefits Issue
Svcs Exceed Auth
Authorized Outpatient-Billed Inpatient
Authorization Requested Denied
Readmission not covered
Insufficient Clinicals Provided to Payer
Not Medically Necessary
Other

2MN Denied by Reason Code vs. Paid by Reason Code 2023-2024




2MN Denied by Payer vs. Paid by Payer 2023-2024
Denied
Paid after Revecore Action
90
80
70
60
50
40
30
20
10
0
AETNA GOLDEN MEDICARE
AETNA MEDICARE ASSURE
AETNA MEDICARE VALUE PLAN
ANTHEM DUAL ADVANTAGE
ANTHEM MEDICARE ADVANTAGE
BUCKEYE MYCARE OHIO
CARESOURCE MYCARE OHIO
DEVOTED HEALTH INC
HOSPICE OF THE WESTERN RESERVE
HUMANA GOLD CHOICE
MEDICAID (incorrect per Epic)
MEDICAL MUTUAL
MEDICAL MUTUAL OF OHIO MEDICARE
MEDICAL MUTUAL SUPER MED
MEDICARE
MEDICARE PART A
MEDICARE PART A AND B
MOLINA MARKETPLACE (medicare sec)
SUMMACARE MEDICARE
UHC MED COMPLETE
UNITED HEALTHCARE CONNECTED MYCARE OHIO
UNITED HEALTHCARE DUAL COMPLETE
UNITED HEALTHCARE MEDICARE
UNITED HEALTHCARE MEDICARE HMO
UNITED HEALTHCARE OF OHIO
WELLCARE BY ALLWELL
WELLCARE DSNP
WELLCARE HEALTH PLANS

Best Practices

For Denial Prevention

Tracking

Thorough tracking and trending of denials

Analysis

Root cause analysis is done consistently and used in order to allow improvements from the front to end of the revenue cycle process

Team

Denials Prevention and/or Resolution team with key individuals and skills set

Approach

Addressing denials from an organization-wide approach with heavy consideration of how financial and clinical factors intersect


Questions?

Thank You