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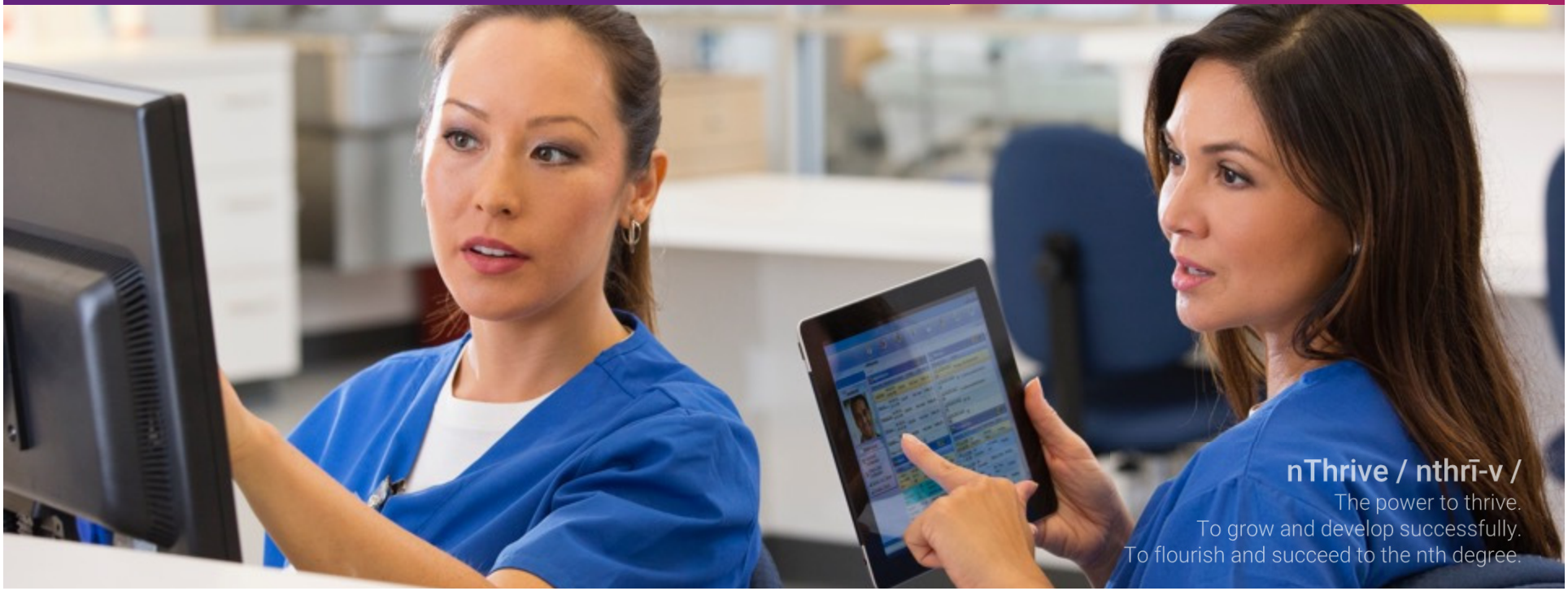


Revenue Integrity in the Age of Value Based Purchasing and the Patient-Centered Revenue Cycle

Arkansas HFMA Summer Conference, August 27, 2020

Presented by // Virginia Gleason, Sr. Manager Advisory Services

Agenda

The Game of Denials

- Current Playing-Field and “Rules” of the Game
- Knowing the Terminology
- Clinical and Coding Traps
- Moving From Management to Prevention
- Rate Your Performance in the Game


Current Playing Field

Cost of Denials: Providers are Playing Defense

$3 trillion

claims submitted

> $262 billion denied,

averaging almost
$5 million per hospital

Change Healthcare, 2017. (Initial denials)

Industry average denial rate between **5-10%**

AAFP, 2010. (Initial denials)

65% of claims denials are never re-submitted

MGMA, 2011.

58% of all denials were commercial in 2016, up from 54% in 2015

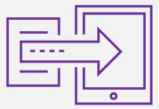
Healthcare Informatics, 2017.

31%

of hospitals manage denials manually

> 60% without an external solution

but plan to purchase one in the next **7-12 months**



HIMSS, 2016.

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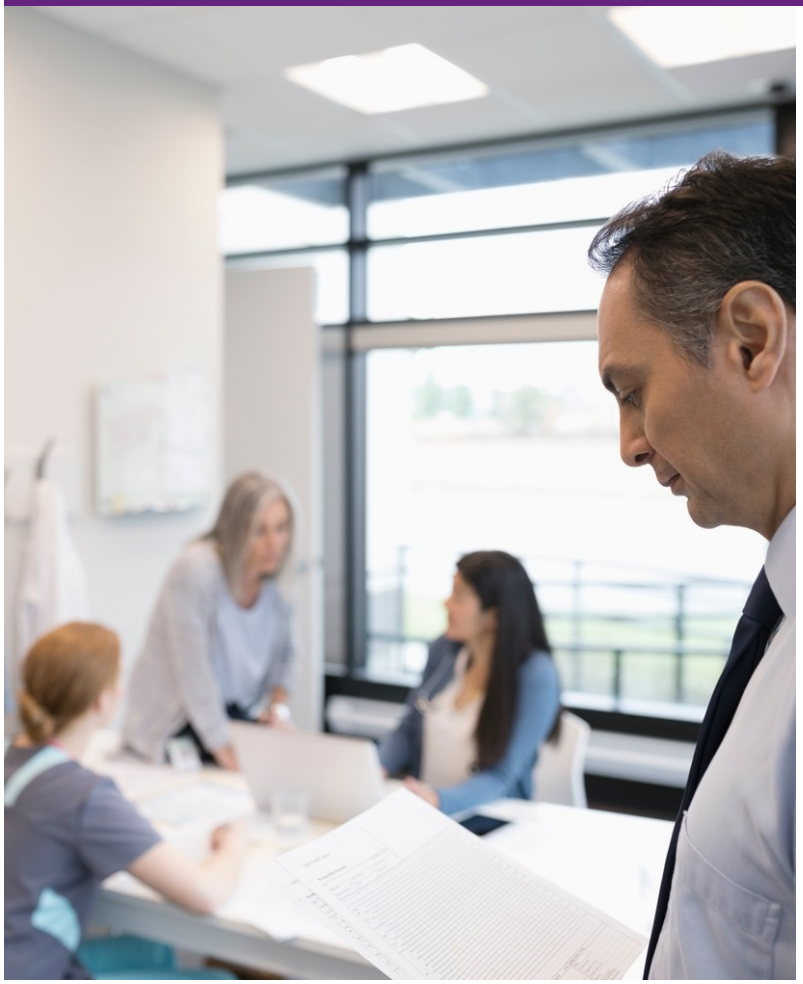
Denials

Most health systems **lose between 3 and 5 percent** of their net revenue as a result of payment denials[1]

The cost to denials makes up an estimated **20% of revenue cycle expenses**[2]

90% of denials are preventable[3] when feedback from denials management is implemented with associated departments



Regulatory Environment

- ✓ **Hospital Readmission Reduction Program (HRRP)**
  - Value Based Purchasing Program
- ✓ **Section 3025 of Affordable Care Act**
  - Payment reductions for “excess” readmission
  - Began October 1, 2012
- ✓ **21st Century Cures Act**
  - Requires CMS to assess hospital performance against other hospitals with similar proportion of dual-eligible patients
  - Began FY 2019
  - Requires estimated payments under the non-stratified methodology (i.e., FY 2013 to FY 2018) equal payments under the stratified methodology (i.e., FY 2019 and subsequent years)
  - Goal to maintain budget neutrality

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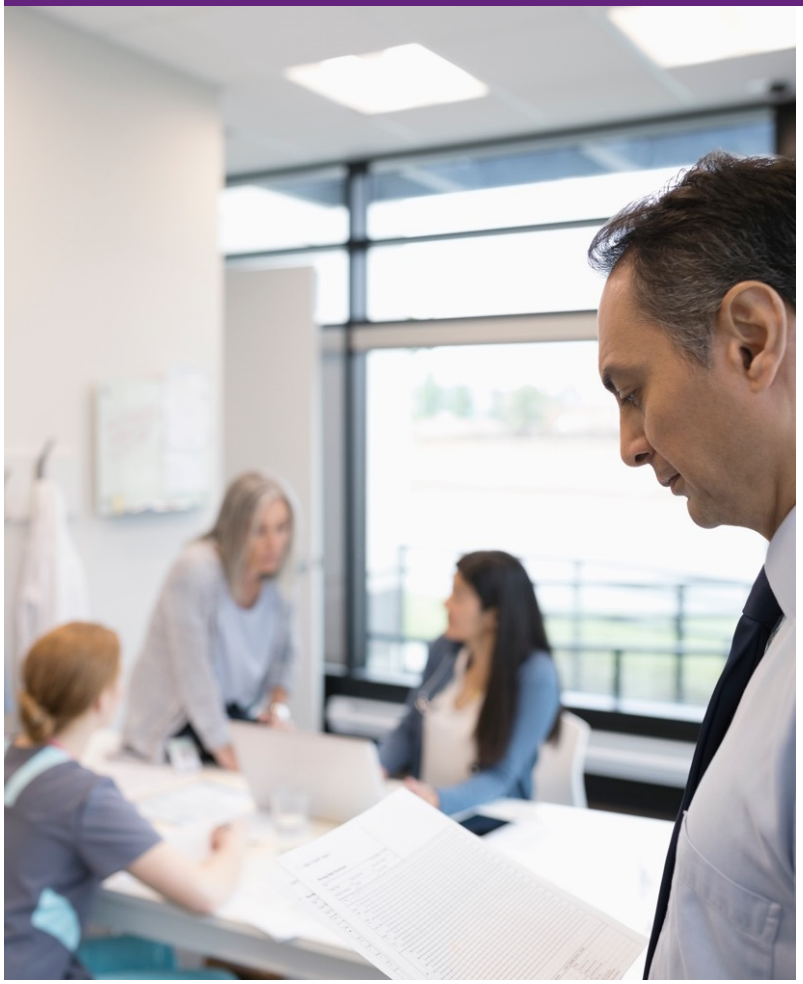

Regulatory Environment

FY 2020 Payment Adjustments
(Many Delayed by COVID)

- ✓ **Based on performance July 1, 2015 – June 30, 2018**
- ✓ **Payment reduction applied to payments October 1, 2019 – September 30, 2020**
- ✓ **Capped at 3% reduction**
- ✓ **Applies to all Medicare DRG payments**

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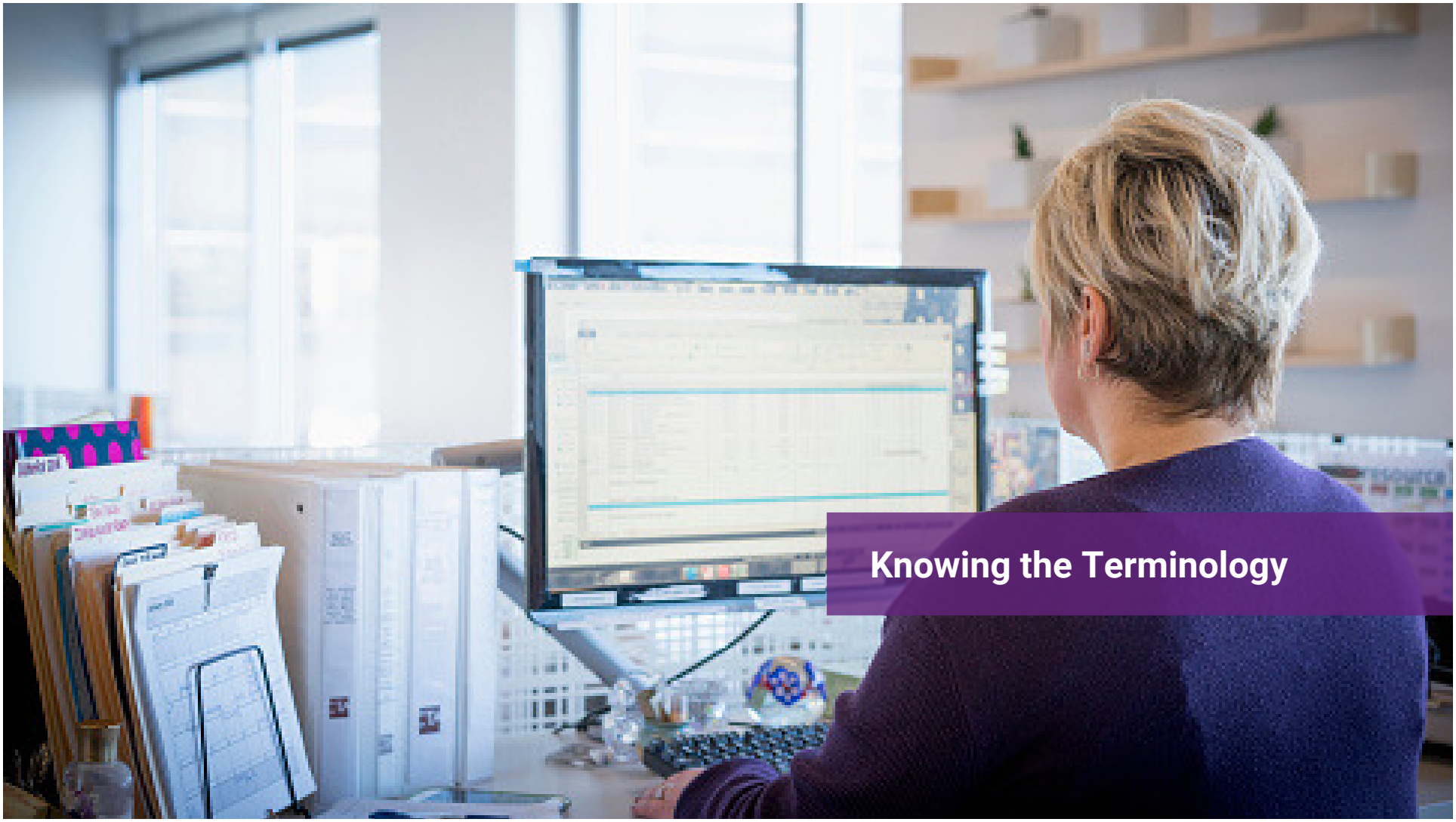
Knowing the Terminology

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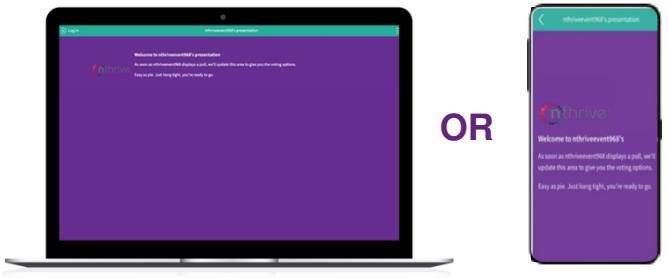

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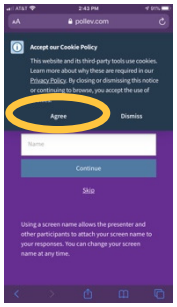

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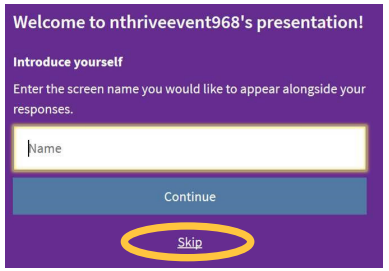

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What is a denial?

Denials Defined

The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional

https://www.healthinsurance.org

Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided.

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Were we paid what was owed for all services provided?

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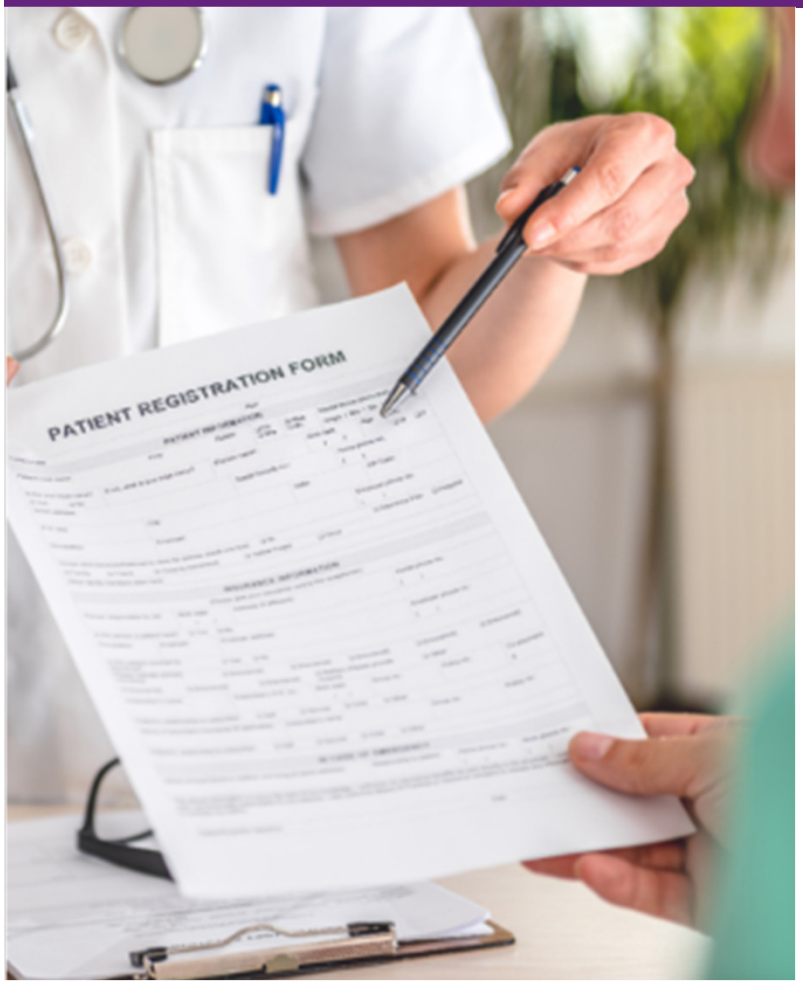

Soft vs. Hard Denials:

Soft Denial – A temporary or interim denial that has the potential to be paid (by the provider or by the patient) if the provider takes effective follow-up action.

- ✓ **Appeal not required**
- ✓ **Examples:** Pending receipt medical records, Denied due to missing or inaccurate information, Pending itemized bill, Pending receipt of invoice

Hard Denial – A denial that has the potential to result in lost or written-off revenue if not overturned by the payor specifically.

- ✓ **Appeal is required**
- ✓ **Examples:** No pre-authorization. Not a covered service. Bundling, Untimely filing

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Vocabulary of Denials Management

Technical

- Administrative Errors
- Missing or Invalid Authorizations
- Coordination of Benefit / Eligibility Issues
- Untimely Billing

Clinical

- Medical Necessity
- Level of Care
- Clinical Validation

Under / Over Payment

- Contractual Difference
- DRG Validation
- Pricing Errors

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Vocabulary of Denials Management

Concurrent

Received during hospitalization
Additional information needed
Opportunity to build the defense
Potential for payment

or

Initial Denial

Received after billing
Additional information needed
Opportunity for appeal
Potential for payment

vs

Final Denial

Write-off
Lost revenue / reimbursement

Denials delay payment and typically require additional work

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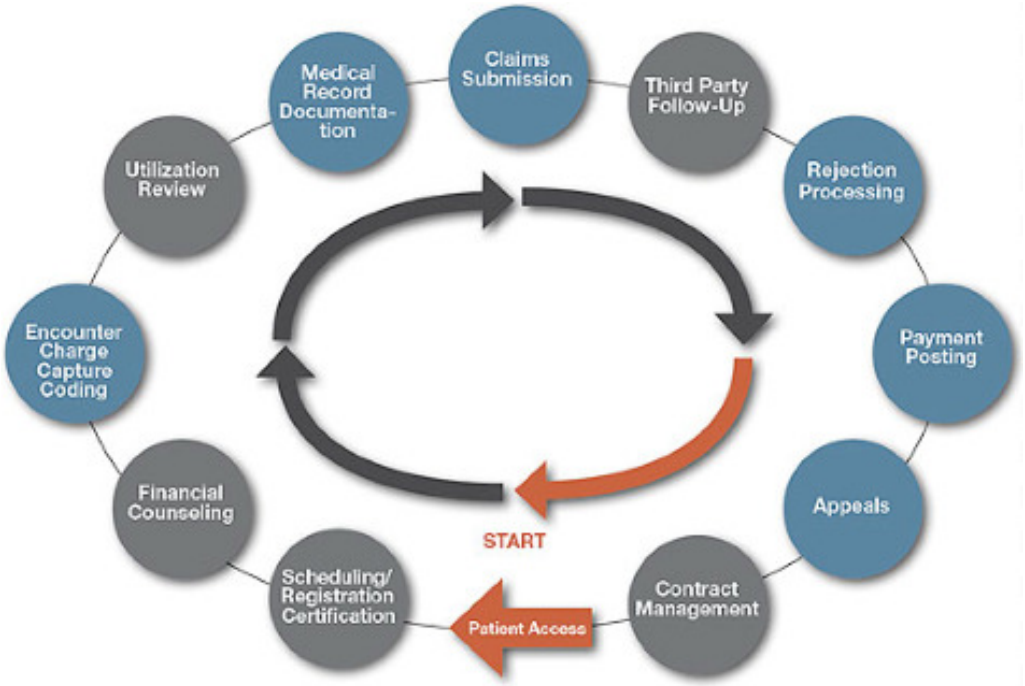
Hospital Revenue Cycle 101



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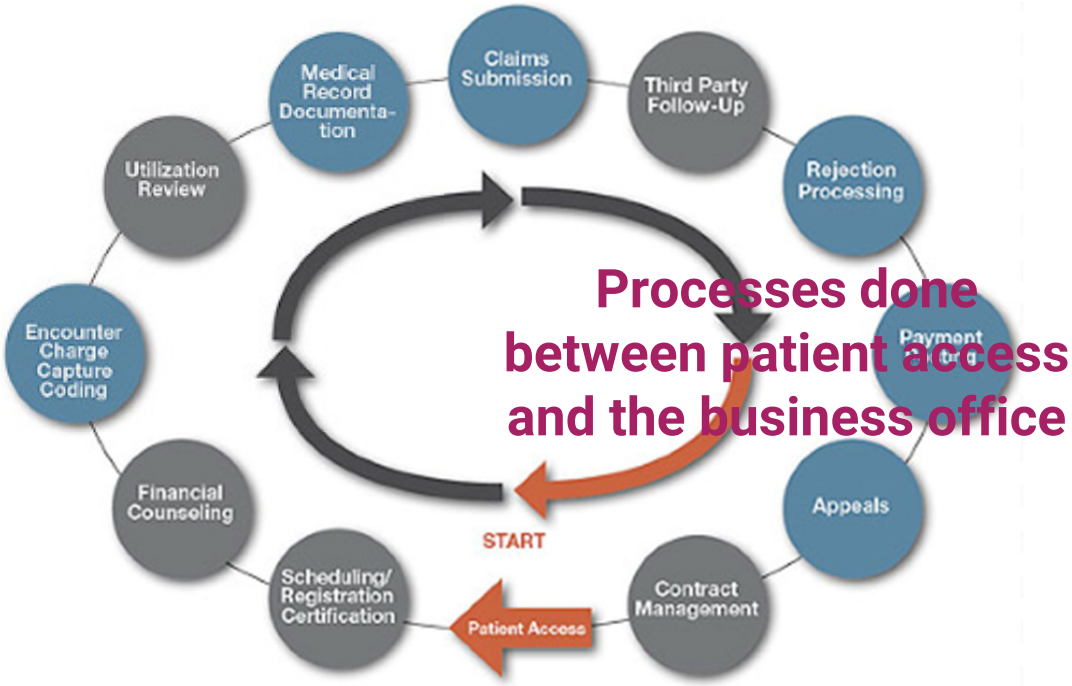
What is the “Middle Revenue Cycle”?



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Clinical and Coding Traps

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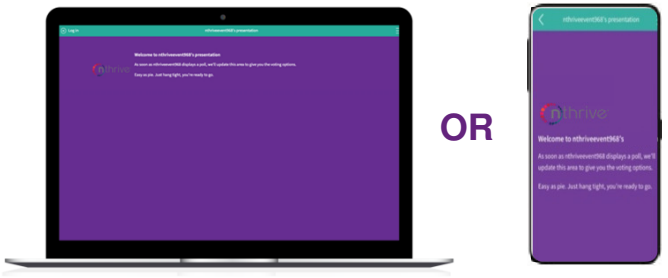

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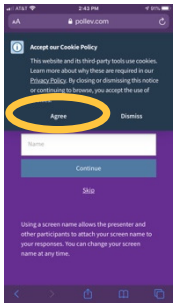

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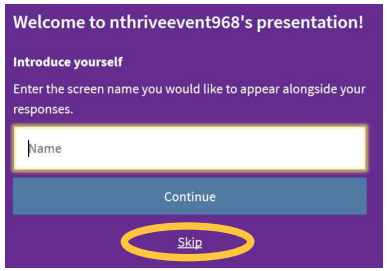

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What words come to mind when you think of clinical denials?

Clinical Validation vs DRG Validation

✓ DRG Validation

- The process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the claim
- Review focuses on documentation and code assignment pursuant to Official Guidelines for Coding and Reporting
- Question to be answered: Did we code correctly?

Clinical Validation vs DRG Validation

✓ Clinical Validation

- Process of clinical review to see if the documented conditions are clinically supported
- Diagnoses documented must be substantiated by generally accepted clinical criteria (e.g. evidenced-based sources)
- Performed by a clinician
  - RAC Statement of Work indicates clinical validation is NOT the coder's responsibility

✓ Potential False Claims Act Liability

- Without clinical validity for documented diagnoses claims submitted could be "for goods or services not actually rendered"

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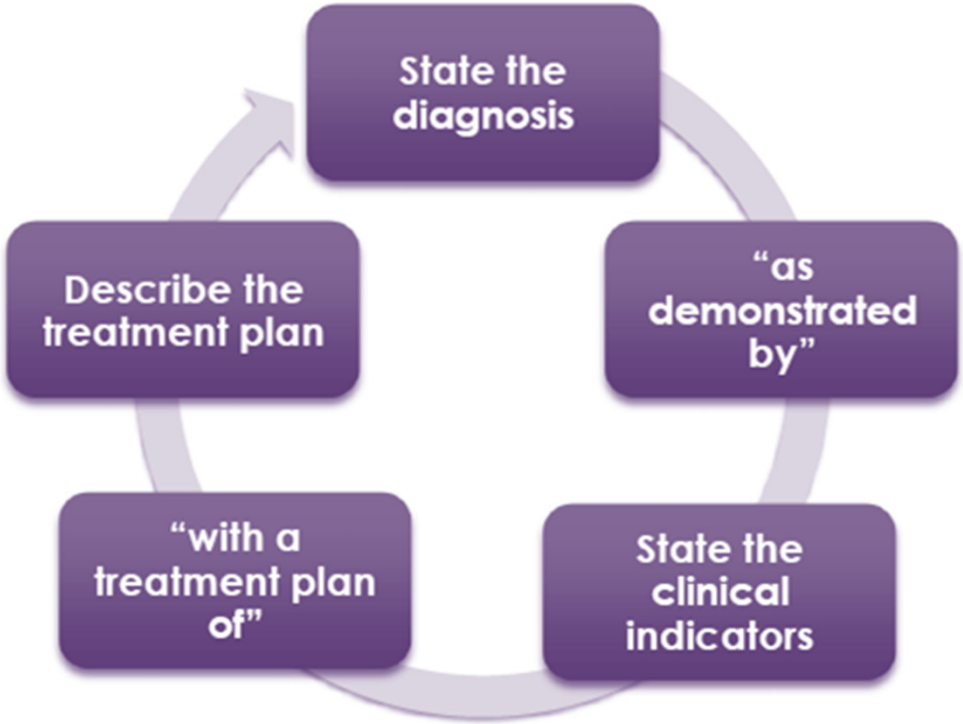
Quality Documentation



Clinical and Coding Traps

ICD-10 Official Guidelines for Coding and Reporting state in Section I.A.19:

Code assignment and clinical criteria: The assignm ent of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that a patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Recovery Audit Contractor Scope of Work

Clinical validation is a process involving "a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the record"

Clinical and Coding Traps

✓ **Referenced Guidelines in Denials**

- Effective at the time of review vs. time of services

✓ **The Guideline at the time of Service governs**

Clinical and Coding Traps

What counts as a readmission under the Hospital Readmissions Reduction Program?

The 30-day risk standardized “unplanned” and “avoidable” readmission measures include:

- ✓ Unplanned readmissions that happen within 30 days of discharge
- ✓ Patients who are readmitted to the same hospital, or another applicable acute care hospital for any reason
- ✓ Readmissions to any applicable acute care hospital are counted, **no matter the principal diagnosis**

Clinical and Coding Traps

Transitions of Care and Readmission Denials

- ✓ “Excess” Readmissions
- ✓ “Related” Admission
- ✓ “Unplanned” and “Avoidable” Readmissions

Readmission Denials

"Related" Admissions

✓ **Avoid the TRAP**

- Same DRG
- Same ICD-10 Diagnosis Code

✓ **Just because the 30-day readmit is the same DRG or Same Diagnosis Code it DOES NOT mean it was an "avoidable" readmission**

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Readmission Denials

“Related” Admissions

- ✓ **Important Definition: Medicare’s QIO Manual, Chapter 4, Section 4240 “Readmission Review”**
- ✓ **QIOs are directed to review the medical record for the initial and subsequent admission for EVIDENCE of**
  - Incomplete care
  - Premature discharge
  - Potential presence of a problem requiring subsequent care
  - Inadequate follow-up arrangements / plan at discharge
  - Cases in which the hospital contributed directly to the need for readmission

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Readmission Denials

"Related" Admissions – Expanded by the Affordable Care Act

- ✓ **Section 3025, "Hospital Readmissions Reduction Program."**
- ✓ **30-Day Readmissions are assumed to be "related" – "unless there is clear evidence that the admissions are unrelated"**

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Readmission Denials

- ✓ The assumption is that the readmission is avoidable.
- ✓ Does the documentation prove otherwise?

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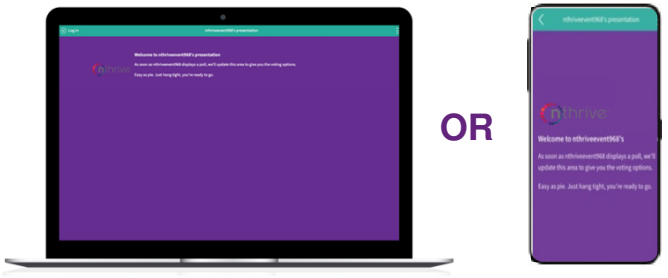

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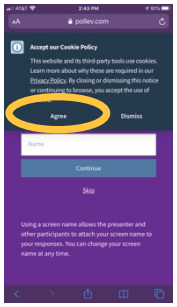

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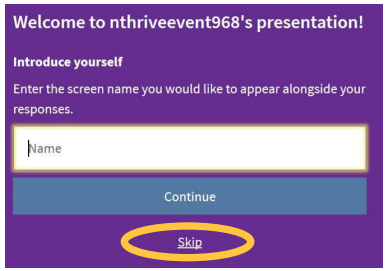

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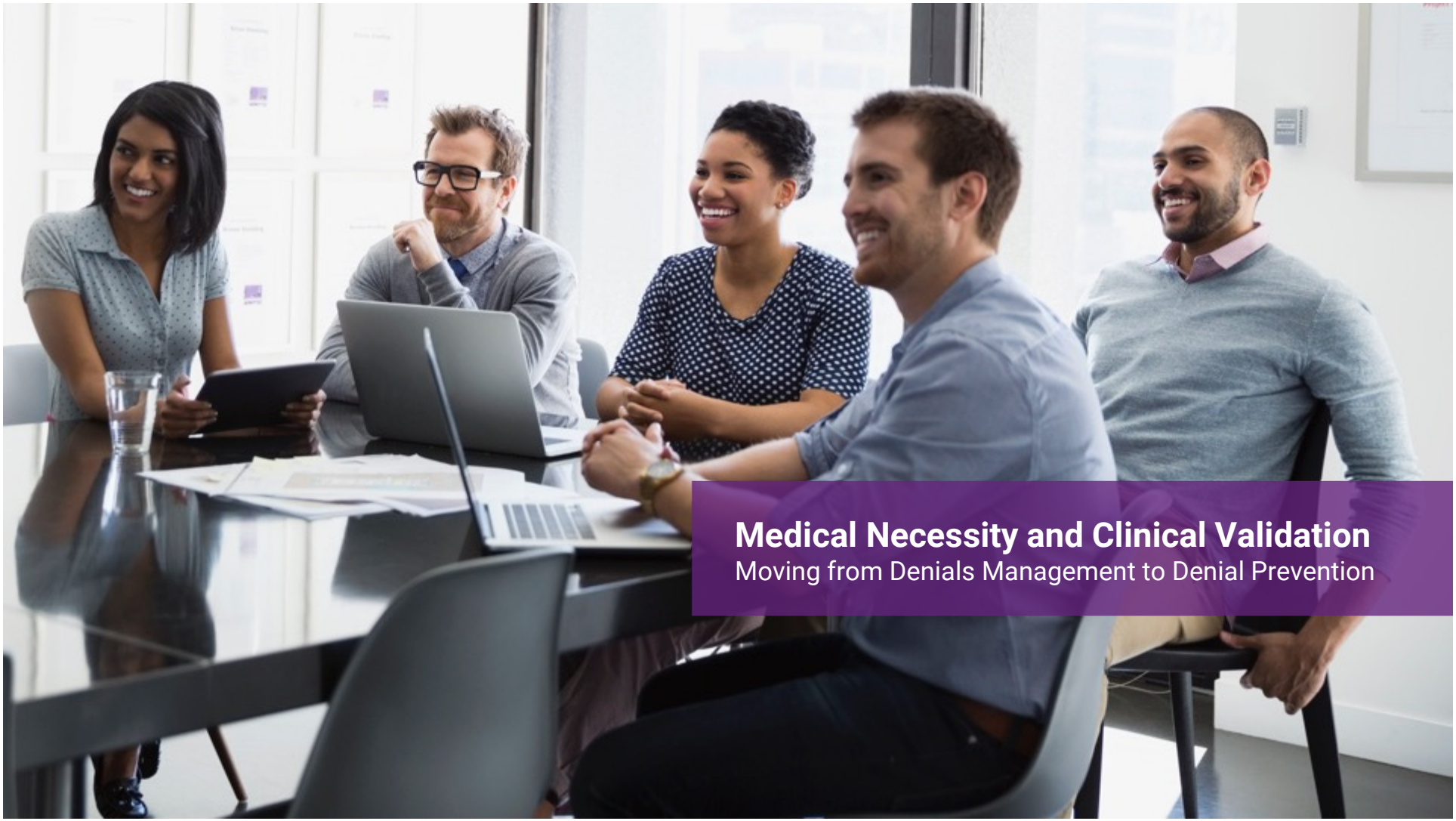
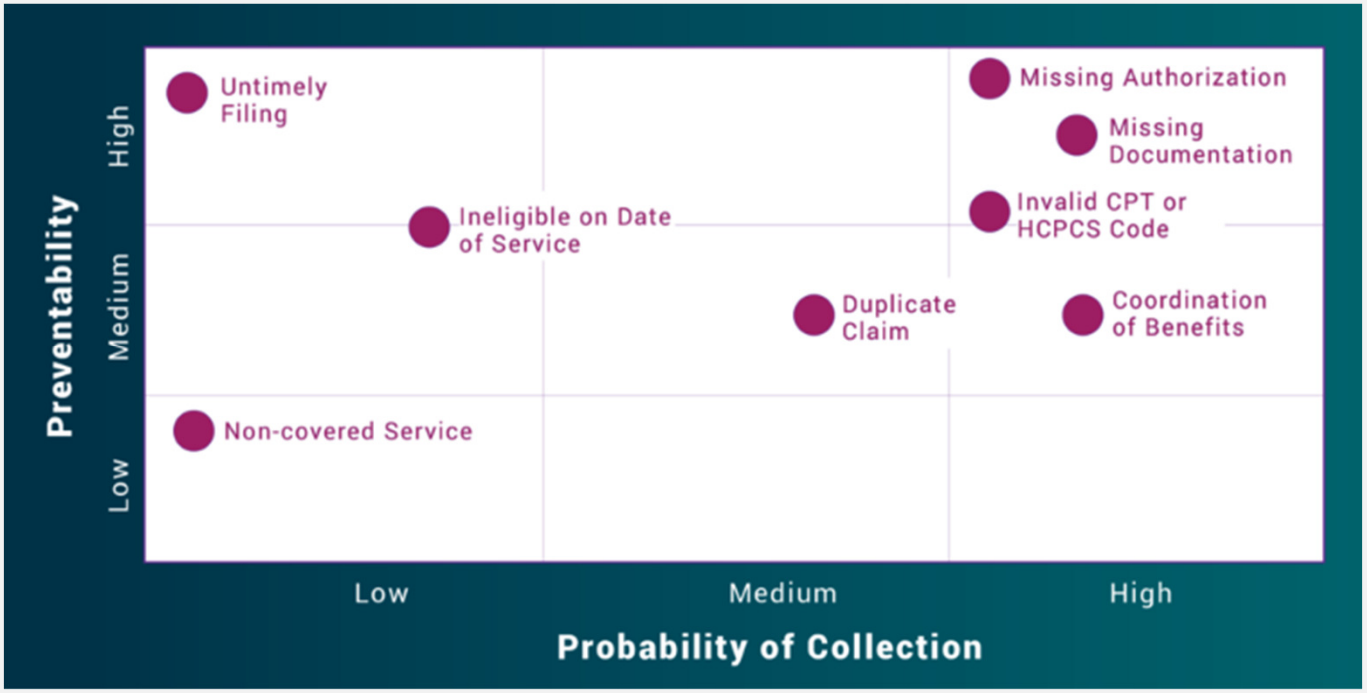
Does your CDI program play a role in denials management?



Medical Necessity and Clinical Validation

Moving from Denials Management to Denial Prevention

Picking the Battle



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Denial Prevention:
Landmarks

Goal is to move away from working denials to systemically preventing them

- Beyond Bill Scrubbers and PAS Edits

Recognize that eliminating 100 percent of denials is not possible

- Continually improve and drive down top reasons
- Small improvements can drive large financial results
- Leverage technology to solve high volume low dollar issues

Proactive vs. reactive

- Denials Task Force incorporating ALL areas
- Payor Engagement
- Root Cause analysis and intervention

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Clinical Denial Prevention:
Bridge the Clinical Denial Gap

Utilization Review / Case Management

- Does the patient “meet criteria” for admission
- Inpatient vs. Observation vs. Outpatient-in-a-Bed

Clinical Documentation Integrity

- Query for diagnostic specificity
- Optimization of DRG

The Gap

Case denied for medical necessity

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Clinical Denial Prevention:
Bridge the Clinical Denial Gap

Medical Necessity is <u>not</u> "meeting criteria"

"Criteria" are only a guideline

An effectively documented H&P is the critical component in establishing medical necessity

- For hospitalization
- For procedures
  - Justification for "setting" vs. "procedure"

Broaden the Scope of CDI and UR

- UR acts as Concurrent Denials Management
  - Action beyond "does it meet criteria"
  - More than sending "the clinical" to payers
  - Drive payer response
- Broaden the view of CDI
  - Documentation does not live in a vacuum (or silo)
  - If CDI is documentation "integrity" vs. "improvement" this includes medical necessity
  - Capturing CCs and MCCs vs. educating physicians on documentation of medical judgement

Mind the Gap: CDI and UR Collaboration

- UR communication to CDI of concurrent denials
- Build a defensible record

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Denial Prevention:
Challenges

Resource and expertise intensive

Perceived inability to capture the denial data

Challenging appeals process

Denial information provided by payers not standardized

Constantly changing information

Requires coordination throughout the organization

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Denial Prevention:
Key Concepts

- **Organizational consensus and commitment**
- **Root cause transparency**
- **Measuring the opportunity**
- **Payor management and involvement**
- **Systems supporting effective tracking and management**
- **Governance, oversight, and accountability**
- **Performance evaluation and feedback**

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Denial Prevention:
Organizational Commitment

Effective denials prevention requires commitment across the organization:

- Business Office
- Patient Access
- Service Areas
- Utilization Review
- Case Management
- Clinical Documentation Integrity
- Managed Care Contracting
- Hospital Leadership

Risks

- ✓ Gaps in accountability and oversight
- ✓ Inability to impact root causes at the source

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Denial Prevention:
Root Cause Transparency

Challenge: Multi-Faceted Root Cause Sources

Scheduling

- Eligibility / Member Cannot Be Identified
- Benefit plan coverage
- Benefit maximums exceeded
- Experimental procedure
- Authorization
- Pre-existing condition
- Medical necessity
- Credentialing

Access

- Benefit plan coverage
- Benefit maximums exceeded
- Coordination of benefits
- Eligibility
- Experimental procedure
- Authorization
- Pre-existing condition
- Medical necessity
- Documentation

Patient Care

- Medical necessity
- Authorization
- Experimental procedure
- Documentation

HIM, Charge Capture

- Documentation
- Medical necessity
- Experimental procedure
- Authorization
- Benefit plan coverage
- Coding (Missing or Wrong Modifiers)

Billing / Collection

- Bundling
- Coding
- Demographic mismatch
- Documentation
- Eligibility
- Authorization
- Pre-existing conditions
- Timely filing
- Coordination of benefits
- Duplicate Denials

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Denial Prevention:

Measuring the Opportunity

Trending denial data by multiple data dimensions including, but not limited to, denial cases and dollars by:

Denial Reason

trend by reason, prioritize based on volume and/or dollars, drill down and link to location within revenue cycle (front, middle, back)

Payor-Specific

total denials, denial reasons and denials as a percentage of claims submitted; trend by payer type or financial class

Service Location

trend by service location and reason – correlates where opportunity lies with a given service line and where within the revenue cycle (front, middle or back)

Denial Prevention:
Payor Management

Scorecards
- Information is power
- Next contract

Payor Websites and Notifications
- Access to updated policies and procedures

Contract Protections
- Build protection into contracts
- Financial impact of policy changes

Payor Relations
- Your representative needs to be part of your team
- Professional Groups
- Local Chapters are a great source of information

All Components are part of the comprehensive strategy to prevent denials

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Rate Your Performance in the Game

Evaluating Performance:

Revenue Integrity Key Performance Indicators

Goal: Mitigating Inaccurate Billing while Not Under-Billing Services Delivered

Two Key Concerns:

- Lowering Compliance Risk
- Ensuring accuracy of charges

Coding and Charging Focus Areas:

- Coding accuracy
  - 95% minimum
- Coding productivity
  - 95% (only 5% of coding load should be in the queue)
- Charging accuracy
  - Monitor missed charge patterns

No metric or KPI is as meaningful alone

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Evaluating Performance:

Revenue Integrity Key Performance Indicators

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

Report and Trend

- Total
- By Payer
- By Service Line
- By Reason
- By Root Cause

No metric or KPI is as meaningful alone

Evaluating Performance:

Denial Prevention Measurements

Challenge: Defining Appropriate Metrics

Denial Write-offs (Final Denials): What Cash/Revenue is being lost?

Initial Denials: What is out opportunity to improve our efficiency?

Appeal Rate: What percent of denied claims are appealed?

Overturn Rate: What percent of appealed claims are overturned?

Cash Delay:
How many dollars or days in the open AR are unpaid due to a denial?

Cost to Overturn:
What is the cost of the resources being used to overturn denied dollars**?**

Evaluating Performance:

Denial Prevention Measurements

Key Metric: **Initial Denial Rate** (Inflow)

$$\frac{\text{Total of Denied Dollars*}}{\text{Total Remitted Dollars*}} = \%$$

- ✓ **Consider concurrent denials**
- ✓ **Consider "anticipated" denials (those identified concurrently, and defense built)**
- ✓ **Consider Initial rate by number of claims or days denied**
- ✓ **Consider drilling down to other areas**
  - By Payor
  - By Service Location
  - By DRG
- ✓ **Generally reported as a gross value**

* over a period of time

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Evaluating Performance:

Denial Prevention Measurements

Key Metric: **Appeal Rate**

$$\frac{\text{Total of Appealed Dollars}}{\text{Total Denied Dollars}} = \%$$

- ✓ Cost and resource capacity impact the %
- ✓ Evaluate the dollars appealed vs claims appealed
- ✓ Used historical overturn rates to find the “sweet” spot
- ✓ Can be net or gross, be consistent

Fighting unwinnable battles vs Leaving reimbursement on the table

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Evaluating Performance:

Denial Prevention Measurements

Key Metric: **Overturn Rate**

$$\frac{\text{Total Won Dollars}}{\text{Total Appealed Dollars}} = \%$$

- ✓ **High overturn rate does not always mean good news, could mean:**
  - Not being aggressive enough in appeal attempts
  - Opportunity upstream

Often a function of Appeal Rate as much as appeal effectiveness

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Evaluating Performance:

Denial Prevention Measurements

Key Metric: **Final Denial Rate** (Write-off)

$$\frac{\text{Total Dollars Adjusted to Denial*}}{\text{Total Net Revenue*}} = \%$$

- ✓ **Evaluate the adjustment reasons**
- ✓ **Generally reported as a % of net revenue**

* over a period of time

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Evaluating Performance:
Outcomes & Feedback

Baseline

- Define the calculation
- Document source
- Trend 6-12 months

Set End Goals

- Decide on the goal for each of the selected metrics
- Use benchmarks as a guideline
- Create revenue based goals

Set Interim Goals

- Create action based milestones
- Take into account other initiatives or KPI that may be impacted

Evaluate Progress Monthly

- Review progress
- Compare to previous month and previous year
- Make action based adjustments

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Evaluating Performance:
Industry Standards*

Denial Volume

- Range 5% - 10%
- 3% considered successful

Avoidable Write-Offs

- Percentage of Gross Revenue and Percentage of Net Revenue
- 2%-5%

Underpayment Recoveries

- Estimated to be 2%-5% (Becker's Hospital CFO Report)

* **Defining Revenue Integrity KPIs, Dec 6, 2019 .** https://www.hfma.org/topics/revenue-cycle/article/defining-revenue-integrity-kpis.html

Evaluating Performance – Challenges:

Root Cause Determination

Root cause analysis can help the define true opportunity and should be based in prevention analysis not assigning blame.

Always:

- ✓ Normalize denial data to enable trend identification
- ✓ Create categories to support root cause analysis and accountability
- ✓ Define actionable steps

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Evaluating Performance – Challenges:
Upstream Processes

Have the denials caused by other departments been explained to other departments?

Can the impact be measured?

Are there clearly defined feedback loops?

Are you communicating across departments?

Do the upstream areas understand their revenue impact?

- Are performance metrics cascading and aligned with organizational goals?
- Are expectations documented and clear?

Evaluating Performance – Challenges:

Actionable Priorities

Admit you can't fix it all at once

What are the issues having the biggest impact to revenue, cash, aging and expense (rework)?

What issues could be fixed quickly? (Snowball)

What does the team have the capacity to complete?

Discuss potential solutions, decide on a course of action

Assign a champion and enable their success

Summary:

Denial Prevention and Management

Embrace continuous improvement– the target is always moving!

Be clear in the goals and business objectives

Ensure **stakeholders throughout the revenue cycle and the greater organization are committed** to the success of the Denials Management and Prevention program

Develop **effective measurement and reporting** to support oversight and drive accountability

Incorporate feedback to the payors into the process, through payor meetings and contract negotiations

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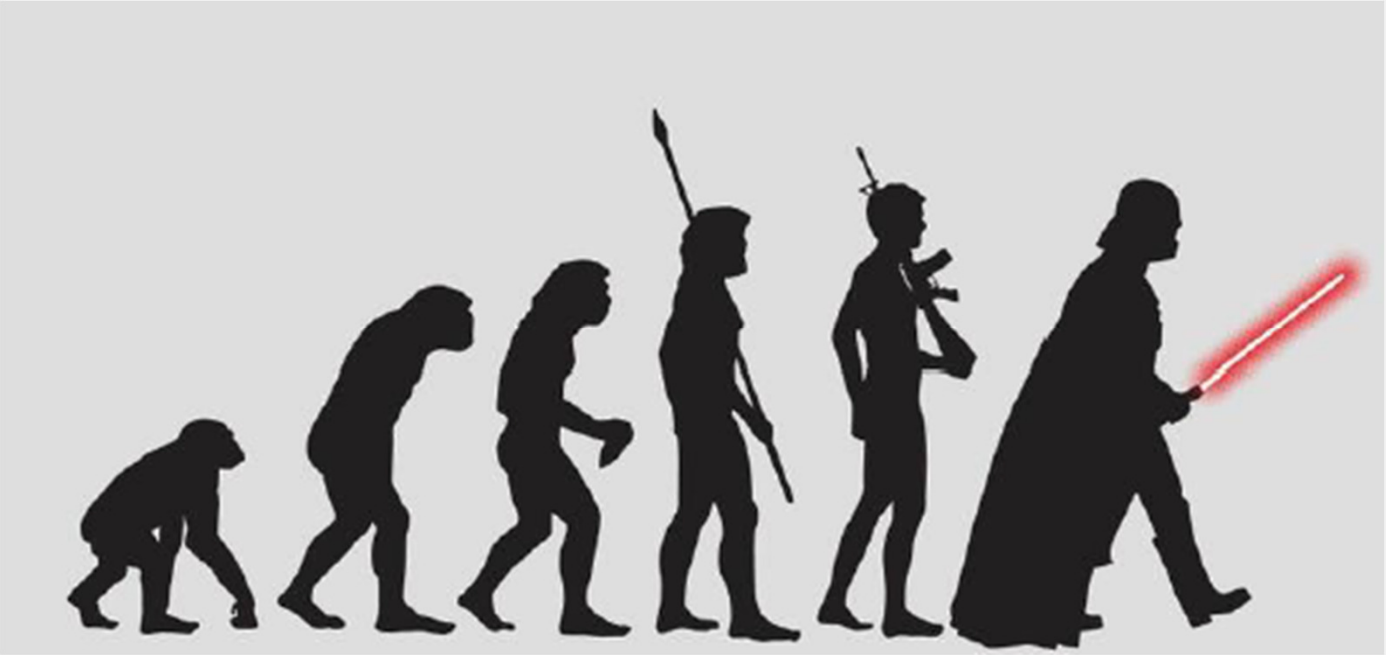
Summary:

Denial Prevention and Management



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