# Outsmarting Eligibility-Related Denials:
## Using Data to Navigate the Complex Landscape

April 25, 2024

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# Your Presenter

**David Mistkawi**

**VP, Access Solutions**

Joined in 2015

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# SSI OVERVIEW

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# SSI OVERVIEW

**We take a people-first approach to business, earning our influence through demonstrated expertise and thoughtful innovation.**

**#ExperienceMatters**

OVER 35 YEARS

Decades in the industry as a **nationally recognized clearinghouse**

Privately-owned, **100% U.S.-based with zero outsourcing**

SSI staff have deep domain expertise with an **average tenure of 15 years**

Best in class support that is **always available & highly responsive**

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850+ EPIC CLIENTS
Baptist Health
DukeHealth
NOVANT HEALTH
WellSpan HEALTH
MultiCare
VANDERBILT HEALTH
UPMC LIFE CHANGING MEDICINE
UNC HEALTH
BRONSON
Owensboro Health
Nebraska Medicine
UHS
SSMHealth
Renown HEALTH
PROVIDENCE Health & Services
uchealth
SSI
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1,150+ ORACLE HEALTH CLIENTS
AdventistHealth
East Alabama Health
MACON COMMUNITY HOSPITAL
Dignity Health
EvergreenHealth
CROZER HEALTH
HUNTSVILLE HOSPITAL
MERCYHEALTH
PennState Health
CGH MEDICAL CENTER
PROSPECT MEDICAL HOLDINGS, INC.
ARKANSAS HEART HOSPITAL
Kaweah Health MORE THAN MEDICINE. LIFE.
CommonSpirit
HUH HOWARD UNIVERSITY HOSPITAL
GONZALES Healthcare Systems
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# 270+ MEDITECH CLIENTS

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# TRUSTED BY 30% OF US HOSPITALS

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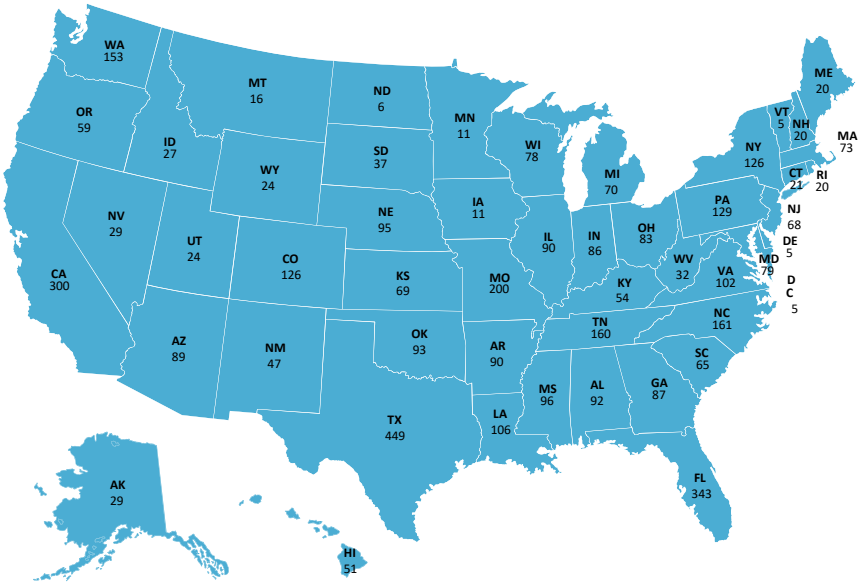
# SSI NATIONAL CLIENT FOOTPRINT

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## Agenda

1. Understanding Eligibility-Related Denials
2. Actionable Measures for Prevention
3. Best Practices for Patient Access
4. Case Studies and Real-World Solutions
5. Industry Updates

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# Understanding Eligibility-Related Denials

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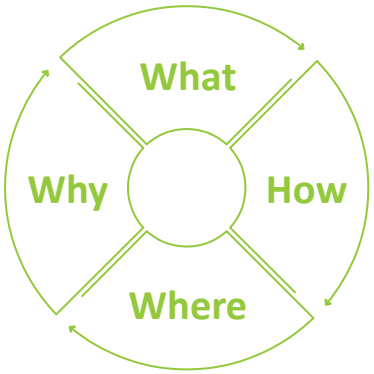
## Root Cause of Denials?

**What:** Lost Revenue and/or Increased Costs

**How:** Overworked, Missing Visibility, Unclear Policies & Procedures

**Where:** Throughout the Revenue Cycle

**Why:** Registration data entry, Pre-authorization and medical necessity, Eligibility and benefits checking, Clinical documentation, Coding, Claim editing, Other regulatory requirements entire revenue cycle, Lack of Automated, Integrated Rule-Based Workflow Tools, Turnover, etc…

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There is no single root cause for denials, nor is there one single trouble area.

Rather, problems that lead to a denied claim occur throughout the revenue cycle.

**…However, following the numbers do provide a path…**

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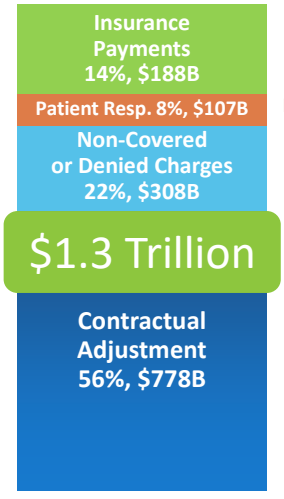
# Breaking Down the Numbers




Does not include Pure Self-Pay

FOCUS

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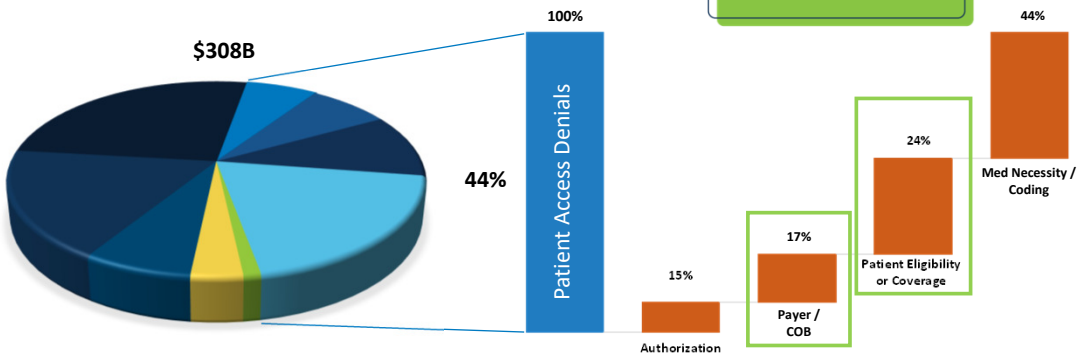
# Start to Break It Down – Areas of Focus

## Non-Covered, Rejected or Denied Charges

**44% of all denials, or $136B**




Source: The SSI Group, 2023

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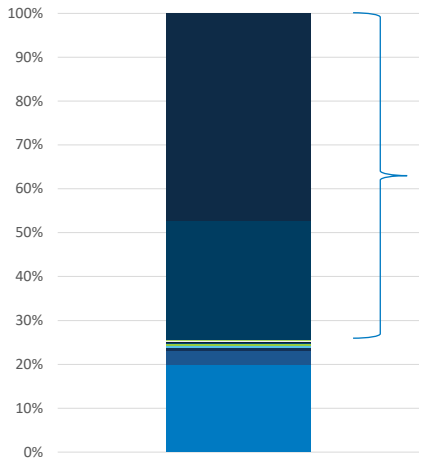
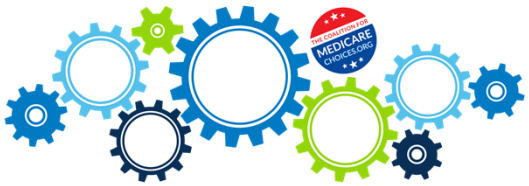
# Who is First, Second, Third…

## Coordination of Benefits



74% Related to…

1. Care may be covered by another payer
2. Not covered by this *payer/contractor*

**Avoidable Denials? $23B, or 17% of Access Related Denials**

Source: The SSI Group, 2023

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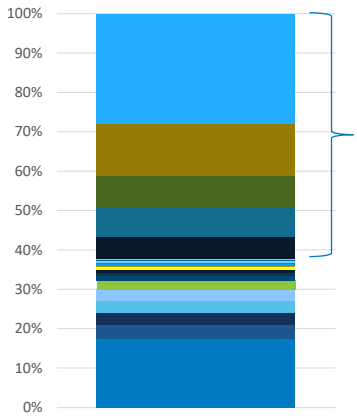
# Insurance Verification Denials

**Patient Eligibility Related Denials**




Source: The SSI Group, 2023

62% Related to…

1. Benefit maximum reached
2. Expenses incurred after coverage terminated
3. Expenses incurred prior to coverage
4. Patient cannot be identified
5. Patient is enrolled in a Hospice

**Devil is in the Details and Worth up to $20B**

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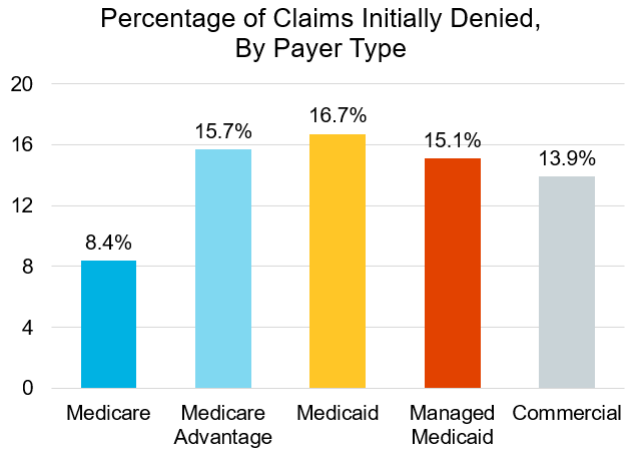
# Private Payers Retain Profits by Delaying Legitimate Medical Claims




Source: Premier National Survey on Payment Delays and Denials, Oct-Dec 2023

- Nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied
- Denied claims tended to be more prevalent for higher-cost treatments - $14,000 and up.
- Over half (54.3%) of denials by private payers were ultimately overturned

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# Pop Quiz

How many dollars per claim are wasted when having to rework a denied claim?

A. $0
B. $1-$39
C. $40-$100
D. >$100

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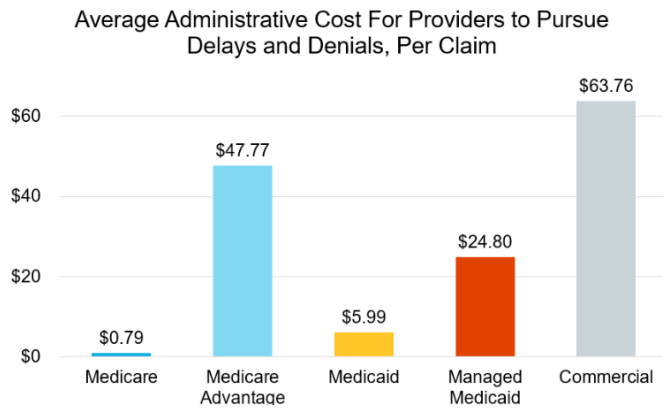
# Private Payers Retain Profits by Delaying Legitimate Medical Claims




- Average of $43.84 per claim, $19.7 billion a year just to adjudicate with payers
- Does not include the costs associated with added clinical labor:
  - $13.29 additional general inpatient
  - $51.20 for inpatient surgery

Source: Premier National Survey on Payment Delays and Denials, Oct-Dec 2023
American Medical Association

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# Days to Rework Eligibility Denials

- 14-17 days adjudication/denial
- 10-14 days typical rework timeframe
- 14-17 days adjudication

38-48 days total

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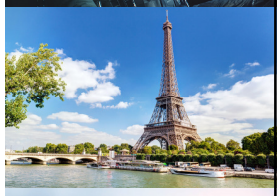
# What is a Day Worth?

**What is worth $137,000 per day?**

A. Trip to the International Space Station?

B. Renting the Eiffel Tower



C. Interest Cost per A/R-Day for a $1 billion system with A/R-days of 45

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# Actionable Measures for Denial Prevention & Best Practices for Patient Access

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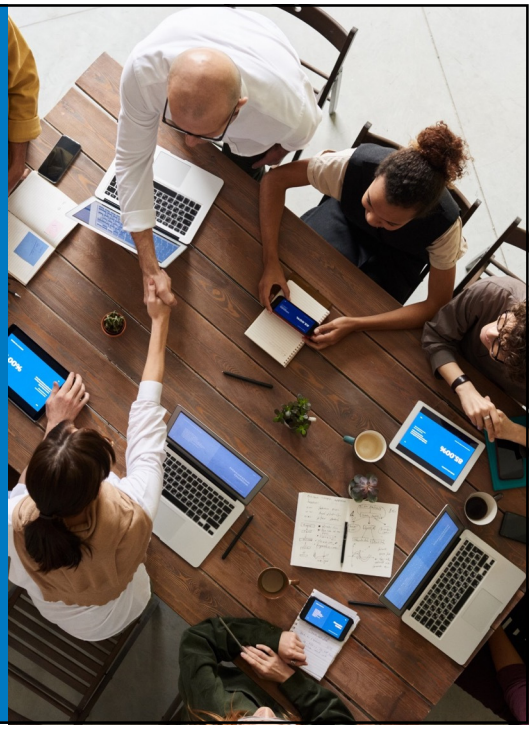
## THE APPROACH

- Implement an Advisory Team
- Define the problem and set your goals
- Define a phased approach by prioritizing the quick wins and biggest issues
- Measure progress continuously and publish the information internally



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# LOW RISK, HIGH IMPACT

- Simple and quick to implement
- No/Few IT resources required
- Minimal Admin decisions required
- Minimal End User Training

- Immediate reduction of rejections, denial, RTPs, recoupments
- Cash acceleration
- Process Improvement

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# Denial Advisory Team Expertise

Prior Authorization

Med Nec / Coding Errors

Coverage / Coordination Issues

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# Technology Partners

Source of Truth

Clearinghouse

Focused Experts

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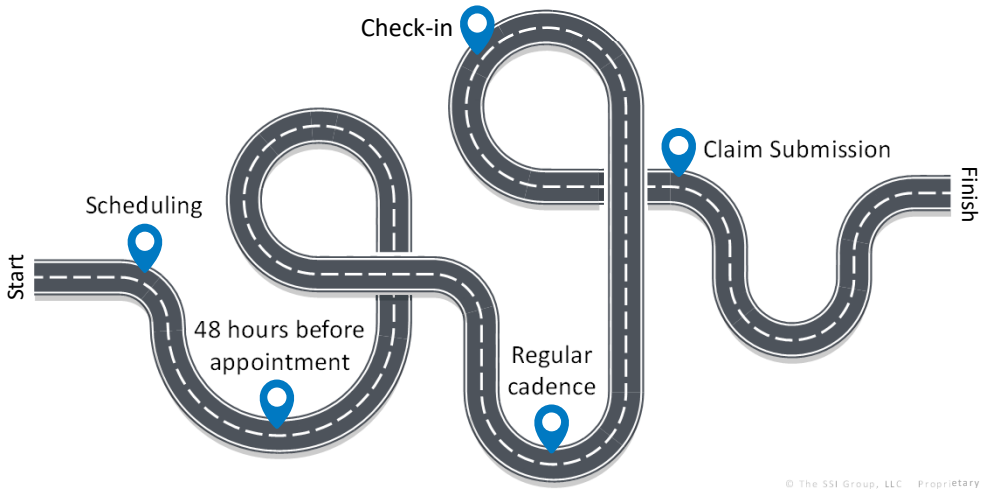
# Best Practice for Eligibility

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# Case Studies and Real-World Solutions

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## COB Denials in AR

**Identify and correct payer order to prevent unnecessary denials**

DENIAL PREVENTION

- Adjustment Reason Codes 109 and 22
- Targeted approach for immediate denial reduction
- Medicaid Managed Care Plans account for the majority of COB denials
- In Arkansas
  - AR Medicaid account for the highest dollar amount
  - Followed by United Health and AR BCBS
- Medicare accounts for the most COB denials

**Overall, this segment account for 17% of all denials**

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# Aide Codes in Large CA Health System

**Example**
MSG*CNTY CODE: 19.
PRIMARY AID CODE: M1.~
EB*D****INCORRECT~
MSG*MEDI-CAL IC INCORRECT
- SENT IC 000, RETURNED
PRIMARY IC - 644~

**Problem:**

- MediCal provides cryptic messages imbedded in the 271 response that, if not properly addressed, will result in downstream reimbursement issues

**Solution:**

- Developed a coding matrix to interrogate the 271 response
- Based on rules, append 271 before posting-back to source of truth. The appended responses guide staff on specific benefits and exactly where to submit the claim

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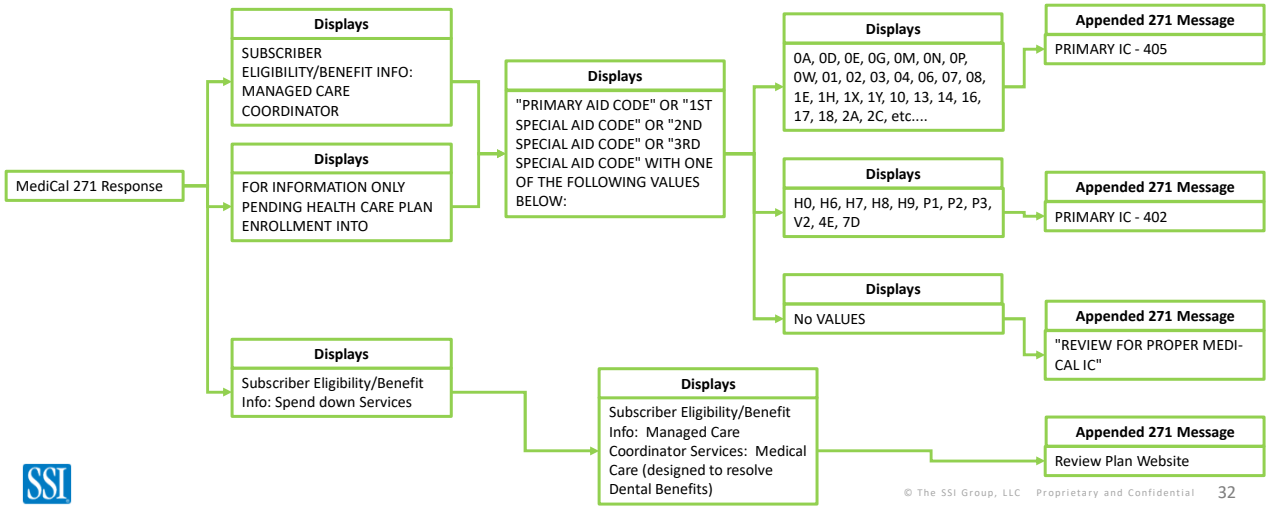
# Aide Codes in Large CA Health System

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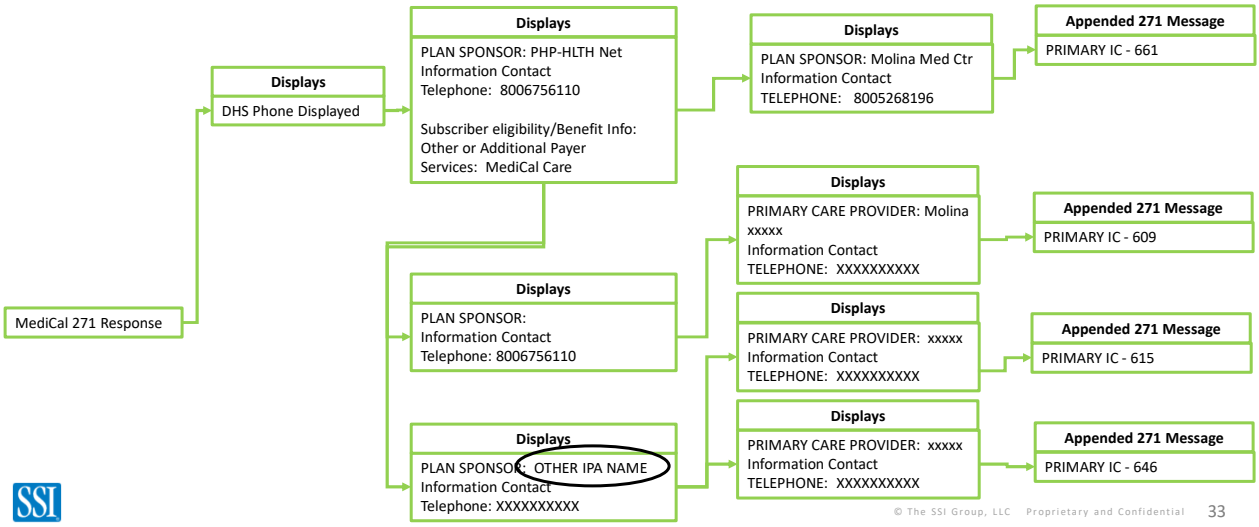
# Aide Codes in Large CA Health System

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# Coverage Denials in MS Health System

| Description | Claim Count | Claim Total |
|---|---|---|
| Contact Following Entity for Eligibility or Benefit Information. | 6513 | $22,699,862.32 |
| Other Coverage Found. | 3949 | $17,509,342.03 |
| Invalid/Missing Subscriber/Insured Name. | 2139 | $9,072,367.57 |
| Subscriber/Insured Not Found. | 1188 | $4,557,422.80 |
| Medicaid Managed Care Coverage Found. | 1120 | $2,287,615.06 |
| Date of Service Not Within Allowable Inquiry Period. | 1008 | $6,536,506.00 |
| Inactive. | 946 | $1,441,583.36 |
| Invalid/Missing Subscriber/Insured ID. Please Correct and Resubmit. | 868 | $3,450,927.55 |
| Patient Birth Date Does Not Match That for the Patient on the Database. | 766 | $3,079,750.53 |
| Active Skilled Nursing Care Spell Days Remaining. | 714 | $2,968,586.84 |
| Open Hospice Election period exists, Review charges service dates. | 702 | $12,523,494.88 |
| Other or Additional Payer Present. | 185 | $559,525.78 |
| Patient is a Railroad Retirement Medicare Beneficiary. Claim should be billed to 99999-0421. | 39 | $2,193.00 |
| Missing Policy Number for Medicare claim | 13 | $320,521.48 |
| Grand Total | 20,150 | $87,009,699.20 |

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# COB Denials in MS Health System

**63% ($2.8M)**

**Reduction in Denials**

**Previous 12 Month Period Before Go-Live**

**$4,418,828**

*22 - This care may be covered by another payer per condition of benefits.*

**12 Month Period After**

**$1,614,841**

*22 – This care may be covered by another payer per coordination of benefits.*

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# COB Denials in MO Health System

**30% ($314K)**

**Reduction in Denials in just 4 months**

**4 Months Before Go-Live**

**$1,059,734**

*22 - This care may be covered by another payer per condition of benefits.*

**After Go-Live**

**$745,600**

*22 – This care may be covered by another payer per coordination of benefits.*

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# COB Denials in GA Health System

| | COB Edits | Denial Reduction |
|---|---|---|
| Medicare | From 6,544 to 1,438<br>**78% Reduction** | Before (Q3 2022) = $1.3M<br>After (Q3 2023) = $1.1M<br>**$200,000 Reduction** |
| Medicaid | From 1,681 to 98<br>**94% Reduction** | Before (Q3 2022) = $623K<br>After (Q3 2023) = $142K<br>**77% Reduction** |

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# Industry Updates

- Audience to Share Experiences

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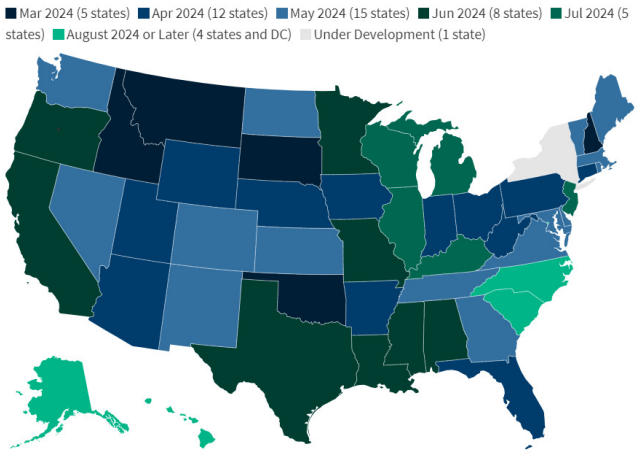
# Anticipated Medicaid Unwinding




Source: KFF

- The Medicaid continuous enrollment provision, which had halted Medicaid disenrollments since March 2020, ended on March 31, 2023
- States began disenrolling people from Medicaid in different months
- As states unwind the continuous enrollment provision patients will be disenrolled due to ineligibility or unable to complot the renewal process
- Millions of people are expected to lose Medicaid coverage during this unwinding period

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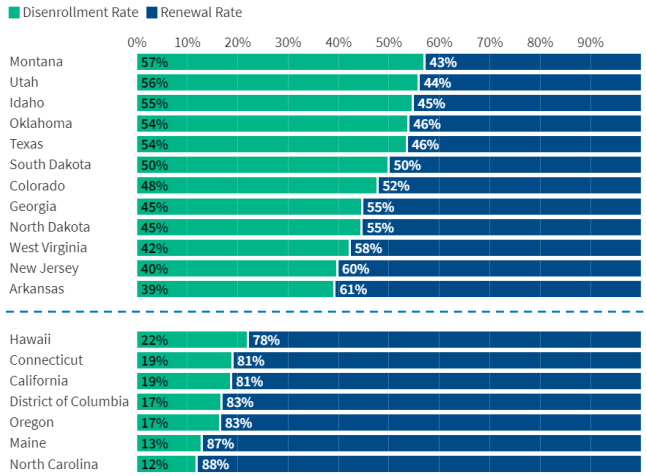
# Medicaid Disenrollment




Source: KFF

- There is wide variation in disenrollment rates across reporting states, ranging from 57% in Utah to 12% in Maine
- 23 million Medicaid enrollees have been disenrolled as of June 14, 2024
- Of all who were disenrolled, 69% were terminated for procedural reasons
- CMS recently announced that the Unwinding Special Enrollment Period (SEP) has been extended until November 30, 2024.
  - Patients now have three opportunities to select coverage
  - Potential changing coverage and confusion for the provider

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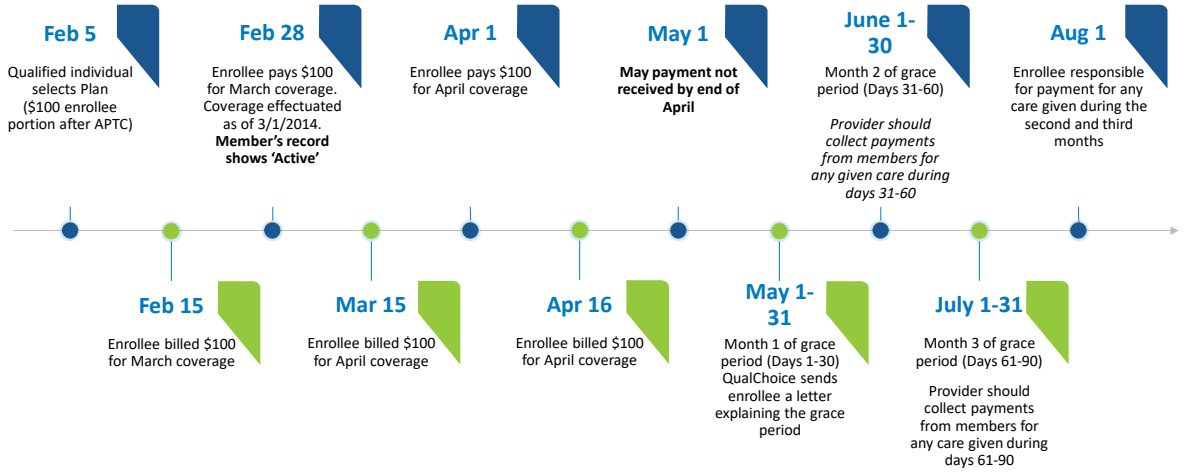
# Affordable Care Act (ACA) Grace Period




Fierce Healthcare / Premier, March 22, 2024

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# Overall Impact on Coverage & Denials?

Nearly one in four people who were disenrolled from Medicaid remain uninsured, according to a **KFF poll**.

Medicaid denial rates from 2022 – 2023 for 44 States - Denials related to coverage

- Increase of 3% in denial dollars
- Increase of 6% in number claim adjustments

- According to CDC estimates published Aug. 5 2024, 8.2% of Americans were uninsured in the first quarter of 2024, up from 7.7% in the fourth quarter of 2023.

- ACA exchange enrollment increased to 16.6 million in the first quarter of 2024, up from 13.3 million in the last quarter of 2023. Federal agencies have worked to steer individuals losing Medicaid coverage to exchange plans.

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