



Denials Management

Controlling and Avoiding Denials

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Presenters



Deloitte.

Robin Gates

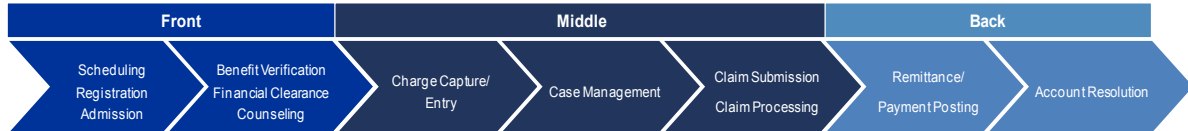
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Robin Gates is a Senior Consultant with Deloitte Consulting LLP in the Service and Operations Extended Business Office Solutions practice. She has over 14 years of experience in the health care revenue cycle, including 3 years of consulting with Deloitte. She has experience in home health care, physician based care, long term acute care hospitals, durable medical equipment and mental health care.

Denials and the Revenue Cycle

Claim Denials – Financial Challenges for Healthcare Providers

- Denial Management is more than a back end Revenue Cycle concern.
- Denials are influenced by all areas of the Revenue Cycle.



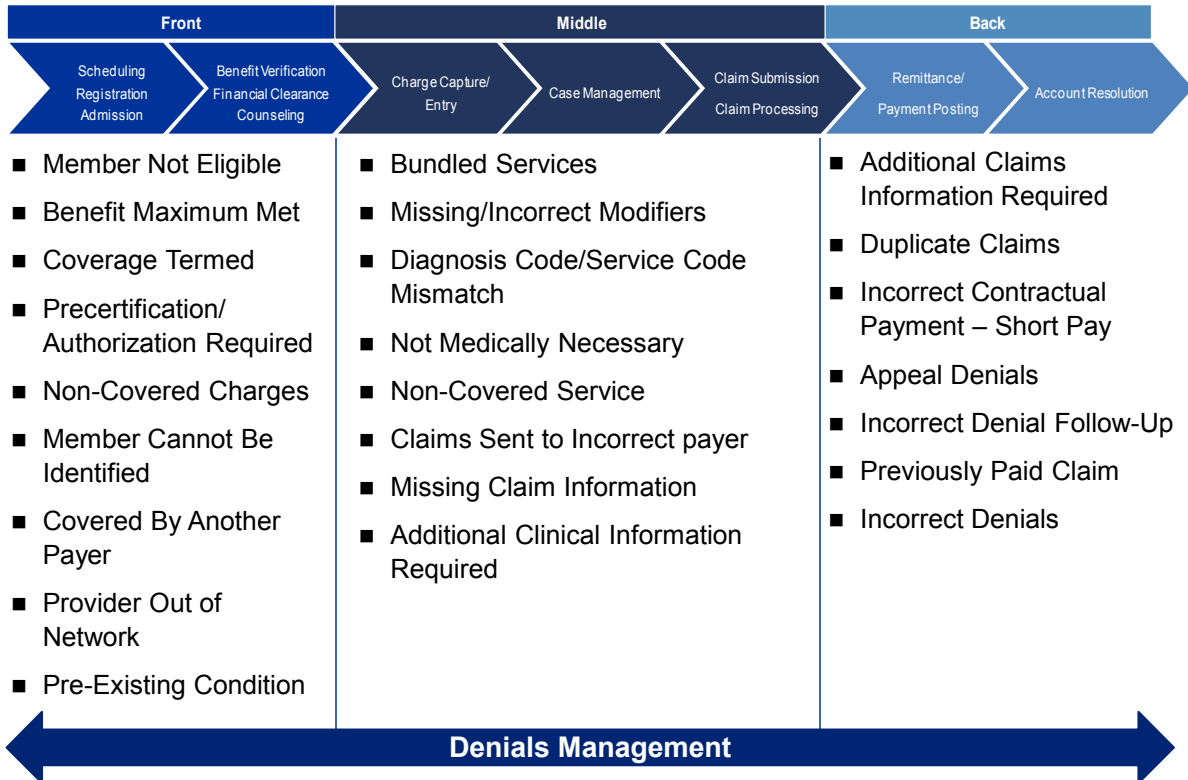
- Numerous studies have been conducted to determine the effect of denials on claims submissions.
 - An average of 5% to 20% of all claims submitted are denied or delayed¹
 - 50% of denied claims are never appealed despite a 67% recovery rate²
 - 3% to 4% of provider claims are never paid³

Denials increase costs and decrease revenue

¹ and ³ Physician Practice Magazine – 2009

² HIPAA & Revenue Cycle Compliance Report – Veteran's Administration 2009

All Areas of the Revenue Cycle Contribute to Denial Volumes



Industry Study

2010 AMA National Health Insurer Report Card (NHIRC)⁴

- The American Medical Association conducted a random sampling of electronic claims from 7 of the largest commercial payers and Medicare.
- Commercial payers participating in the 2010 NHIRC included Aetna, Anthem Blue Cross and Blue Shield, Cigna, Coventry Health Care, Health Care Service Corporation, Humana and UnitedHealth Group.
- The payers were measured on 4 key metrics:

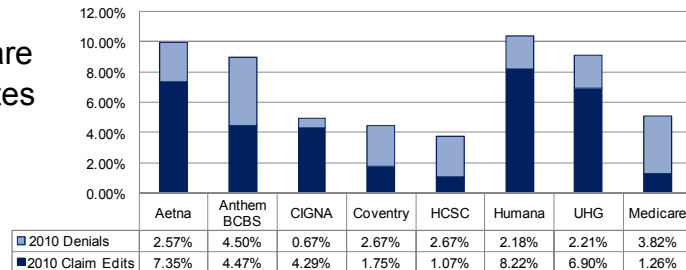
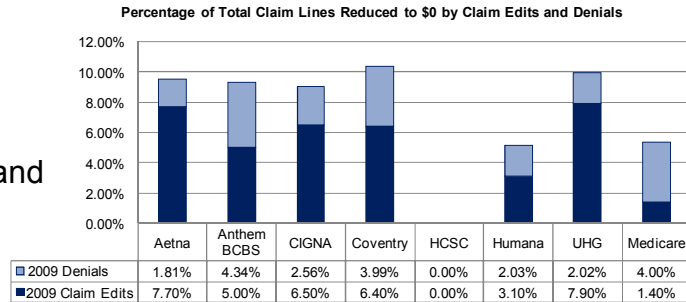
Accuracy ~ Denials ~ Timeliness ~ Transparency

FINDINGS

- ✓ **1 in 5 claims are processed incorrectly by payers**
- ✓ **Providers spend 25 additional days complying with payer processing requirements.**
- ✓ **Up to 14% in provider revenue was spent meeting these payer expectations**
- ✓ **The accuracy rate averaged: 80%**
 - **Coventry Healthcare, Inc was the highest at 88.41%**
 - **Anthem BCBS the lowest nationally at 73.98%**

2010 AMA National Health Insurer Report Card (NHIRC)⁴

- The AMA divided denials into front end claim edits and back end denials both of which resulted in claim lines reduced to \$0.
- 2.0M claims were sampled
- 7.6M claim edits were utilized
- The percentage of claim lines denied averaged 7% for 2009 and 2010.
- Aetna maintained denial rates between 9.5% and 10% in both 2009 and 2010.
- Cigna, Coventry and Health Care Services Corporation denial rates were below 5% in 2010.



Top Denials By Payer Applied to the Revenue Cycle Functions



- **Coverage Termined**
 - Aetna 24%
 - Coventry 46%
 - UHG 60%
- **Non-Covered Charges**
 - Aetna 22%
 - Cigna 27%
 - Humana 41%
- **Member Cannot Be Identified**
 - Anthem BCBS 5%
 - HCSC 16%
 - Medicare 6%

- **Coding (Claim Edits)**
 - Aetna 74%
 - Anthem BCBS 87%
 - Cigna and Coventry 93%
 - HCSC 76%
 - Humana 92%
 - UHG 72%
 - Medicare 63%
- **Bundled Services**
 - Aetna 13%
 - Cigna 11%
 - UHG 3%
 - Medicare 10%
- **Additional Clinical Information Required**
 - Coventry 20%
 - HCSC 23%

- **Missing Information**
 - Anthem BCBS 20%
 - Medicare 6%
- **Incorrect Contractual Payment – Short Pay**
 - Aetna 19%
 - Anthem BCBS 26%
 - Cigna 15%
 - Humana 17%
- By CPT Code Category**
 - Medicine 16%
 - Radiology/Imaging 12%
 - Surgical 12%
 - E & M 10%



Denial Management Solutions

Steps to Managing Denials

1. Define the types of denials and categorize as Controllable/Avoidable.

Can the denials be avoided prior to claim submission?

Can the outcome of the appeal for payment be controlled after the denial?

What percentage of denials are in each category?

2. Further categorize denials by significance and impact to Revenue Cycle.

Which departments/functions contribute to the most significant denials?

Within the claim life cycle, where can these denials be controlled/avoided?

3. Track denial history and trends by denial type, charge code, payer, etc.

Which payers represent the majority of denials?

What is the write off volume due to denied claims?

Which denial types have the biggest impact on revenue?

4. Develop KPI's around denials and impact to billing and collections.

Are denials decreasing or increasing seasonally?

Where are the areas of opportunity to reduce denials and increase collections?

5. Build work flows to process current denials and to avoid/reduce future denials.

Are the work flows clearing denials and producing cash?

When will the new processes positively impact the denial volume?

Are all payer denials impacted by these changes?

Remember denials do have a direct impact on clean claims and reimbursement

Controlling and Avoiding Claim Denials

1. Define the types of denials and categorize as Controllable/Avoidable.

Can the denials be avoided prior to claim submission?

Can the outcome of the appeal for payment be controlled after the denial?

What percentage of denials are in each category?



■ Categorization:

- **Controllable:** the outcome after the claim is denied can be anticipated
 - **Uncontrollable:** the outcome after the claim is denied cannot be anticipated
 - **Avoidable:** processes and procedures can reduce the possibility of a denial
 - **Unavoidable:** the denial cannot be prevented through processes and procedures
- The number of denied claims in each category provides a better understanding of the volume of denials that can be reversed and those that will result in a write off.
- This categorization can be utilized on 835 denials as well as system collated denials.

Controlling and Avoiding Claim Denials

2. Further categorize denials by significance and impact to Revenue Cycle.

Which departments/functions contribute to the most significant denials?

Within the claim life cycle, where can these denials be controlled/avoided?

- Denial significance can be assigned according to severity, resolution priority or financial impact.
- Determine where in the claim life cycle the denial originates.
- Understand that denials can be the result of several issues and all pain points should be addressed.

3. Track denial history and trends by denial type, charge code, payer, etc.

Which payers represent the majority of denials?

What is the write off volume due to denied claims?

Which denial types have the biggest impact on revenue?

- Denials management by payer establishes where the risk lies (i.e. contract management, payer billing management, etc.)
- Review write off history and financial impact of previous denials.
- Impact to revenue includes delay in payment as well as zero payment.

Controlling and Avoiding Claim Denials

4. Develop KPI's around denials and impact to billing and collections.

Are denials decreasing or increasing seasonally?

Where are the areas of opportunity to reduce denials and increase collections?

- KPI's can be a combination of industry best practices and the business requirements.
- Understand seasonal denial increases and develop an action plan.
- Determine where in the Revenue Cycle the denial originates to isolate risk.
- There can be multiple areas of risk which result in a single denial.
- Examine how departments/functions impact claim denials.

5. Build work flows to process current denials and to avoid/reduce future denials

Are the work flows clearing denials and producing cash?

When will the new processes positively impact the denial volume?

Are all payer denials impacted by these changes?

- Once work flows are built, results must be tracked.
- Monitor denial volumes of resubmissions and appeals to ascertain denial reversal rates
- Examine further any payers that respond unfavorably and adjust work flows/processes as needed.

Case Study: RS Medical

Overview: RS Medical



- RS Medical is a leading provider of physician-prescribed home electrotherapy devices, braces and stimulators.
- They have served more than 1 million patients in all 50 states since the company's inception in 1990.
- RS Medical 's products are supported by the most comprehensive physician and patient services in the industry.
- 36 satellite offices located across the country with 200 Account Managers.
- Providing services to physicians in more than 195 metropolitan markets.

Compliance Accessories



RS-FBG™
Full Back Conductive Garment

Enables patients to easily apply pads on difficult-to-reach back locations without assistance.



RS-LB™
Low Back Conductive Garment

Enables patients to apply pads on difficult-to-reach low back locations without assistance.

Bracing



RS-LSO™
Low Back Orthosis

Provides relief for non-surgical patients with low back pain.



RS-LFS™
Lumbar Function System

Provides comfort and support for post-surgical patients during recovery and beyond.

Relieve pain



RS-TENS Plus™
Transcutaneous Electrical Nerve Stimulator

Personal electrotherapy for symptomatic relief and management of acute and chronic pain.

Improve function



RS-2m™
Muscle Stimulator

Treats a variety of conditions for improved muscle function.

Overview: Extended Business Office Solutions (EBOS)

Deloitte acts as an **Extended Business Office (EBOS)** and works side by side with clients to supplement and augment the internal efforts focusing on claims resolution strategies that improve net revenue, reduce bad debt and accelerate cash collections.

Deloitte's strategies have resulted in \$1.5B in payments to clients of \$4.2B in worked A/R and \$580M in recovered denial dollars

Extended Business Office Programs	Denials Management and Resolution	Claim Status Automation	Process Improvement Insights	Proprietary Technology
<ul style="list-style-type: none"> Ongoing collection of targeted aged accounts receivable (e.g., accounts aged >180 days) Focused low dollar/high volume account follow-up System conversion support (e.g., pre go-live cash acceleration and/or wind down of legacy system accounts receivable) Strategic cash acceleration programs that fund large organizational initiatives (e.g., system implementations or transformational engagements) Early out Worker's Comp and No Fault account management 	<ul style="list-style-type: none"> Mapping of multiple payor denials to a standard set of denial categories Analysis, trending and enhanced reporting of denial issues Proprietary web-based request tracking system  	<ul style="list-style-type: none"> Electronic claim status inquiries to all eligible payors Use of standard HIPAA transaction sets 276/277 Route all electronic responses to appropriate party for resolution, using web-based workflow Utilize proprietary screen-scraping capabilities to enhance follow-up efforts 	<ul style="list-style-type: none"> Routine analysis of accounts receivable and denial trends Customized web-based management reporting package Tracking log of identified process issues Communication of key findings through frequent client status updates  	<ul style="list-style-type: none"> HIPAA compliant data-capture solution Proprietary Claims Management System (CMS) for automated workflow CMS can upload information into client's patient accounting system for rebilling Enterprise-wide Request Tracking System Proprietary web-based tools to drive claims follow-up and denial resolution workflow processes

Deloitte and RS Medical A/R Recovery Project



Deloitte's Extended Business Office Solutions (EBOS) Practice was engaged by RS Medical to support an internal initiative to liquidate a backlog of third party claims and accelerate incremental cash flow.

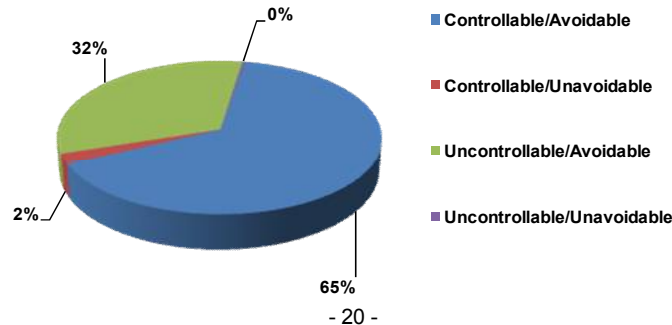
- Only 45% of claims were paid within 60 days.
- Collectibility on claims >120 days was between 3% and 6%.
- 11% of the open A/R was denied or delayed for claim edits
- System limitations did not allow for denial tracking or financial impact analysis.
- Formal processes for denials management were reactive and department specific.

The EBOS team isolated and identified denials on the initial A/R to determine the pain points, areas requiring process updates and viable appeal resolutions. The first 4 of the 5 Denial Management steps were completed by EBOS through deep dive analysis, staff interviews and claim follow up.

- 1. Categorize denials as Controllable/Avoidable.*
- 2. Determine significance of denials and impact to Revenue Cycle.*
- 3. Track denial history and trends.*
- 4. Develop KPI's around denials and impact to billing and collections.*

RS Medical: Categorize Controllable/Avoidable

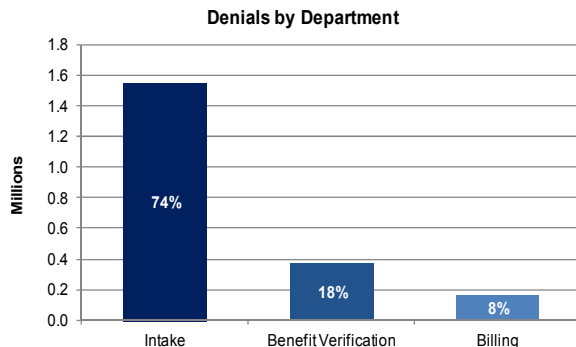
- In November 2008, Deloitte utilized the Controllable/Avoidable denial categories to determine where the majority of RS Medical's denials resided.
- The analysis of the denied claims revealed:
 - **Controlled/Avoidable** denials represented 65% of the total denials.
 - **Uncontrollable/Avoidable** denials represented 32% of the total denials
- With 97% of the denials categorized as avoidable, understanding where these denials originated was vital.
- The 65% of claims that were controllable became the focus of the collection effort while recommendations for process updates were developed.



RS Medical: Significance and Impact

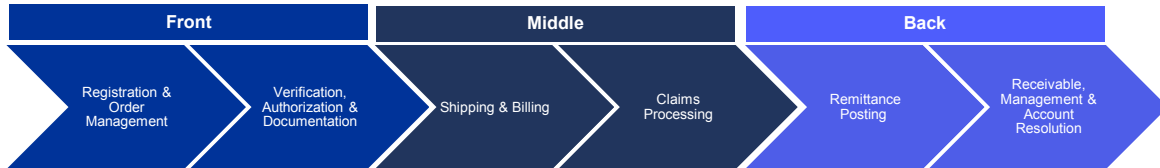
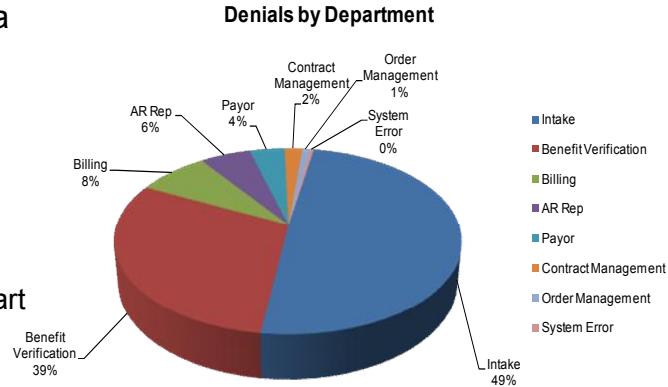
- The top five Controllable/Avoidable denials constituted 51% of the denied A/R and 49% of the denied volume.
- 74% of the claims were denied due to missing or incomplete medical documentation which required appeals and claim resubmission.
- Although these denials could potentially be reversed, preventing the denials on the front end would allow for fewer claims aging past 60 days.

Controllable/Avoidable		
Denial Category	#	\$
Additional Information Required	2,456	\$ 800,710
Not Medically Necessary	2,262	\$ 751,114
No Authorization	697	\$ 140,844
Other Insurance	524	\$ 229,019
Invalid HCPCS/Modifiers	470	\$ 161,654
Subtotal	6,409	\$ 2,083,340
Other	1,077	\$ 2,013,060
Total	7,486	\$ 2,405,694



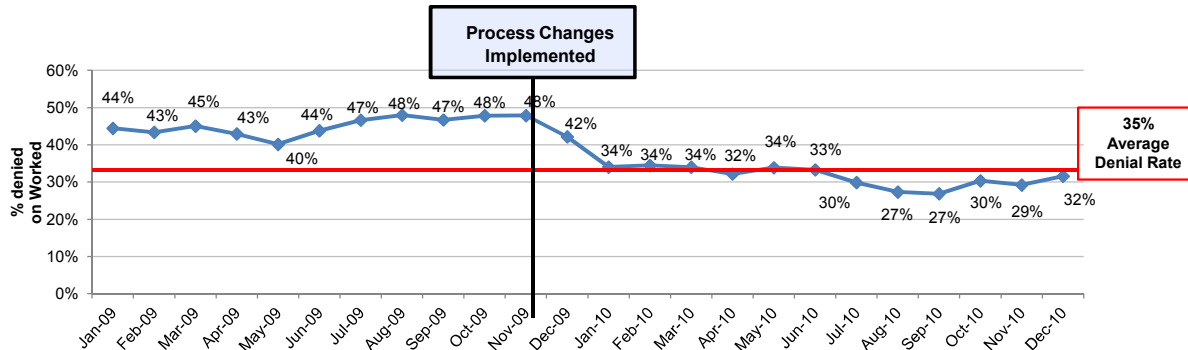
RS Medical: Significance and Impact

- DME provided additional challenges as the majority of the document collection and coding is conducted prior to rendering services or at initial intake.
- 82% of invoices were denied as a result of front end processes
 - The top three Benefit Verification denials are Benefit Maximum Met, No Authorization and Other Insurance
 - Claims denied for additional documentation (LOMN, CMN, Chart Notes) represented 48% of the Intake denials.
 - Only 8% of invoices are denied as a result of Billing errors

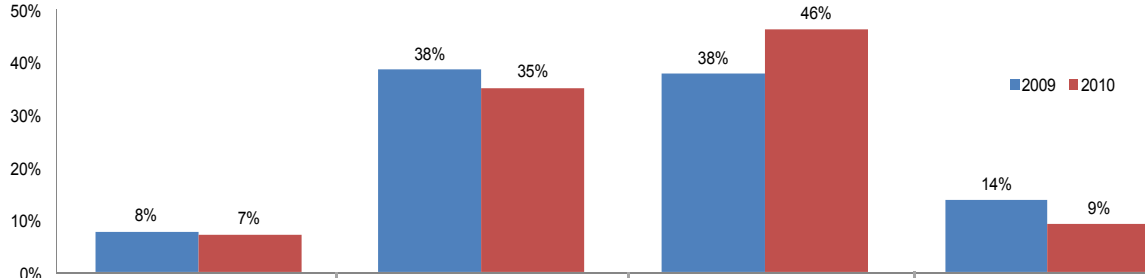


RS Medical: History and Trends

- EBOS provided monthly findings and process recommendations to assist RS Medical in managing denials and focusing on areas of concern.
- In November 2009, measures were taken by RS Medical to correct existing denials while refining front end processes to prevent further denials.
- As the EBOS team worked to reverse the current denials, the client's team addressed the front end process issues identified by Deloitte thus bridging the denial gap.
- Deloitte also provided access to their proprietary Claims Management System work list tool for use by RS Medical managers to assist in creating and assigning follow up queues by financial class, department and team.



Denials by Function



Contract Management

- Plan procedures not followed
- Bundled/Unbundled
- Provider contract expired

Intake

- Additional Info Needed
- Not Medically Necessary
- Not Eligible to Provide Service
- Incorrectly Prescribed
- Liability/Work Related Claim
- Incorrect/Incomplete Rx
- Not Prescribed by Physician
- Service Not Provided/Documented

Benefit Verification

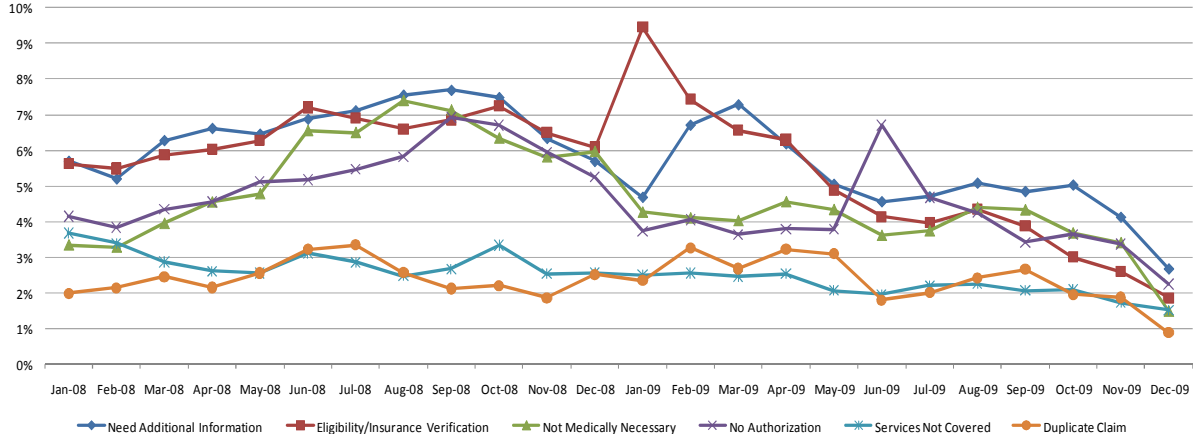
- Member Not Eligible
- Other Insurance
- Non-Covered Charges
- Authorization/Referral Needed
- Out of network provider
- Patient not identifiable
- Coverage Termined
- Benefit Maximum Met
- Capped Services

Billing

- Incorrect Coding
- Past Timely Filing
- Billing Error
- Previously Paid
- Qualifying Service Missing
- Missing/Incorrect Claim Info

RS Medical: History and Trends

- The Top 5 denials were also trended to determine seasonal increases and decreases
- The decreases were further reviewed to determine where timing and process changes had the most impact
- The increases allowed for further visibility into additional areas of concern
 - Eligibility/Insurance verification denials increase at the first of the year.
 - No Authorization denials are cyclical and dependent on the span of the authorization provided by the payer.



- ✓ Clinical documentation requirements were defined for account managers so the supporting documentation information was obtained during the first physician meeting.
- ✓ Payer contract database was expanded to include billing guidelines and requirements.
- ✓ Contracts were negotiated to address the denial issues uncovered in the EBOS findings.
- ✓ Products not covered by payers were listed and defined so as to reduce denials for non-covered services.
- ✓ Authorizations and benefit verification is required on all product sales with a 3 day lag implemented between initial contact and delivery of product.
- ✓ RS Medical developed billing guidelines to ensure the clean claim rate allowed for payments on first submission.
- ✓ A/R follow up processes were developed to reduce the amount of time a claim remained unresolved.
- ✓ Continued management of denials allows for new and recurring issues to be addressed more timely.

Results of Denial Management Implementation



- Paid on first submission increased from 45% in FY08 to 70% in FY10 Q4.
- Collection on A/R >120 days improved more than 300%
- \$3.9M in cash was collected on denial` reversals
 - Payer specific findings and deep dive analysis allowed RS Medical to update processes on 11 of their top payers and collect \$770K in additional cash
 - The top 5 denials were overturned at a rate of 27%
- Monthly meetings and work sessions allowed for a more proactive approach to denial management and clean claim rates.

Q&A

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