CPAs / ADVISORS

blue

Denials

Proactive and Reactive steps to build success within the Revenue Cycle

AGENDA

- Introductions
- Icebreaker video
- Definition of denial
- Strategies for success
- Leveraging what you have
- Technology opportunities
- Appeals
- Q&A

Icebreaker video

Can we relate?

When we say the word “denial” what does that really mean?

A simple definition -

The refusal of something that is requested or desired

Synonyms of DENIAL –

**Refusal*

**Withholding*

**Withdrawal*

**Rejection*

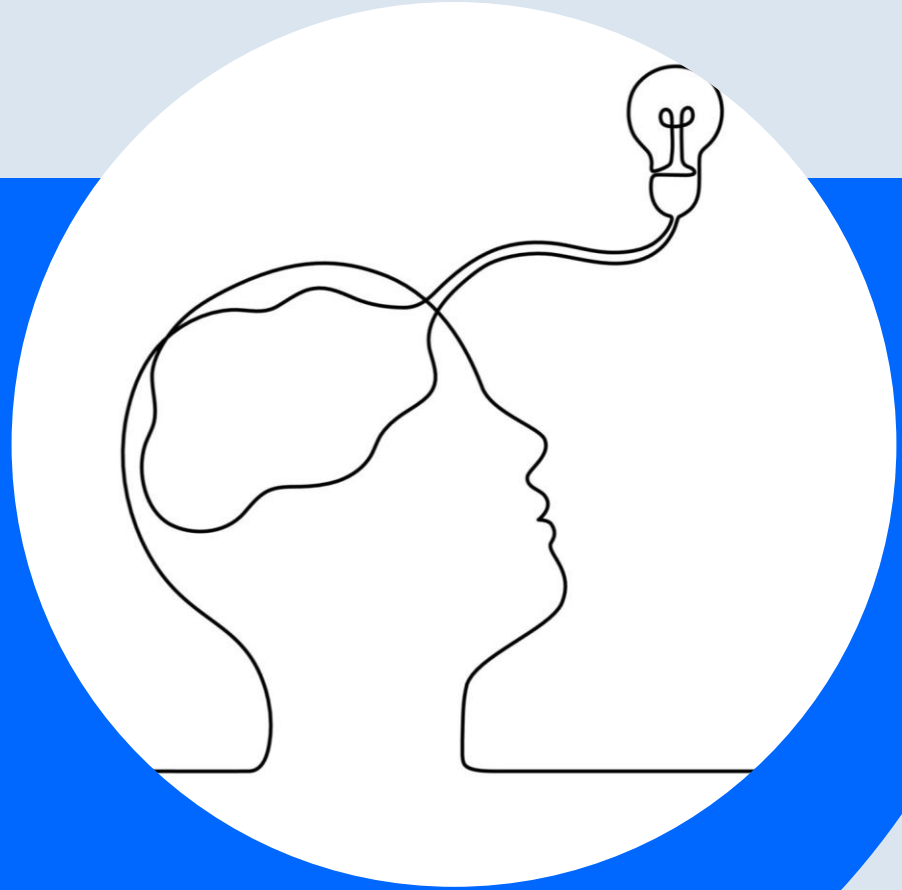
**Dismissal*

**Rebuff*

Regardless of your definition, it is important to make sure you and your support team(s) are on the same page in how you handle all forms of denials

How do you know.....

- you have a denials problem
- how big of a problem you have
- what is being prioritized
- who is working on the various types of denials
- what is being done to fix the current denials and to help avoid new ones
- which ones are avoidable and which ones are not
- etc



Possible signs of denials

- Net collection % by payer(s) is trending lower than expected
- Contractual % by payer(s) is trending higher than budgeted
- Claim volume for rebills is up
- Productivity concerns with billing/collection teams
- Overall cost to collect continues to increase
- Aging of Account Receivables > 90 days continues to grow and appears to be unworked or not worked timely

Words of Caution

- Don’t be into the blame game
- Don’t jump to conclusions but seek out facts
- View things as opportunities instead of problems
- Don’t work in silos
- Don’t give up

A starting point for success

It takes a village

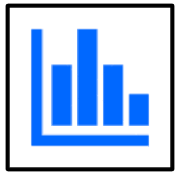
(TEAM)

- Multi-disciplinary
- Focused Revenue Cycle committee w/ adhoc members
- Clear agendas and timelines
- Prioritized and meaningful expectations (be realistic)

Data and analytics

(The Story)

- Host system data
- Coding/CDI/UR data
- Clearinghouse data
- Post bill payer data
  - 835
  - Paper remits
  - Correspondence



Measure, Track & Trend

(KPI's)

- Industry benchmarks
- Department/service line specific
- Standardized cadence
- Goal setting
- Cross-sectional sharing

Communication

(A Golden Key)

- Open dialogue between leaders and staff
- End-to-end education
- Consistent sharing of KPIs and their meaning
- Cheerleading/Celebrating wins
- Accountability/coaching and tough discussions

Working in reverse is a great way to determine where you have gaps and issues within the Revenue Cycle and tells “the story” of how well you and your team(s) are doing

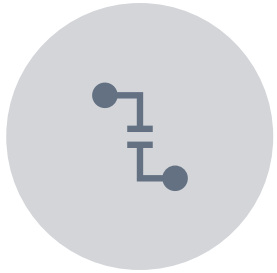
Taking a close look at the results of your processed claims will tell you a lot about your up-stream workflows, items within your control. It will provide insight into what is working well and what is not

You’ll also find elements that are out of your control (payer nuances); however, this will allow you to determine what needs to be better understood and possibly addressed for future claims

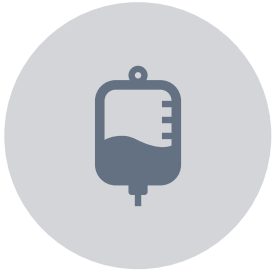
This is considered a REACTIVE approach

What Is Root Cause?

Root cause is made up of: What, Where, When, Why, How and Who



Trace the process backwards to reveal the initial problem(s), dissecting where the breakdowns are occurring and where they could be avoided



Document which denials are repetitive (volume), high dollar as well as which ones are unique (situational vs circumstantial)

Denials can have a snowball effect within the Revenue Cycle processes so be timely, methodical and intentional in your approach

Remittance Posting (CARC)

Electronic remittance posting is performed by using the ANSI 835 format. Within the electronic file, standardized Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) exist

What is a CARC code and the purpose

- The CARC provides the primary reason for an adjustment and is used to describe how a claim was processed and paid or adjusted
- The CARC is made up of two (2) components.
  - The two alpha characters are referred to as the Claim Adjustment Group Code:
    - CO- Contractual Obligation
    - OA- Other Adjustment
    - PI- Payer Initiated Reductions
    - PR-Patient Responsibility
    - CR-Corrections and Reversal
  - The proceeding numeric values of 1- 300+ and alpha characters that start with A, B and P have associated descriptions/definitions of how the claim is being adjusted

Example of numerical codes & descriptors

26	**Expenses incurred prior to coverage.** *Start: 01/01/1995*
27	**Expenses incurred after coverage terminated.** *Start: 01/01/1995*
29	**The time limit for filing has expired.** *Start: 01/01/1995*
31	**Patient cannot be identified as our insured.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
32	**Our records indicate the patient is not an eligible dependent.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
33	**Insured has no dependent coverage.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
34	**Insured has no coverage for newborns.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
35	**Lifetime benefit maximum has been reached.** *Start: 01/01/1995 | Last Modified: 10/31/2002*
39	**Services denied at the time authorization/pre-certification was requested.** *Start: 01/01/1995*
40	**Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
44	**Prompt-pay discount.** *Start: 01/01/1995*
45	**Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)** *Start: 01/01/1995 | Last Modified: 07/01/2017*

Example of alpha codes &descriptors

A0	**Patient refund amount.** *Start: 01/01/1995*
A1	**Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.** *Start: 01/01/1995 | Last Modified: 11/16/2022*
A5	**Medicare Claim PPS Capital Cost Outlier Amount.** *Start: 01/01/1995*
A6	**Prior hospitalization or 30 day transfer requirement not met.** *Start: 01/01/1995*
A8	**Ungroupable DRG.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B1	**Non-covered visits.** *Start: 01/01/1995*
B4	**Late filing penalty.** *Start: 01/01/1995*

Remittance Posting (RARC)

RARC codes are used in conjunction with CARC codes. They can often be overlooked or not utilized correctly which slows down the resolution of claims, leading to inefficiencies and unnecessary work

What is a RARC code and the purpose

The RARC provides additional detail to convey more specifics regarding how the claim was processed

There are two (2) types of RARC codes, Supplemental and Informational

Supplemental

- ✓The majority are considered Supplemental and are referred to as RARCs without further distinction
- ✓Supplemental RARCs are used to share additional information to the CARC on the remittance advice or the explanation of benefits (EOB)

Informational

- ✓The informational RARC is considered or referred to as an alert and is used to share processing facts and are not related to a specific adjustment or CARC

*RARC codes do not stand alone

Example of RARC codes & descriptors

RARC codes range from two (2) to four (4) digit alpha (M or N) combined with numerical values

M1	**X-ray not taken within the past 12 months or near enough to the start of treatment.** *Start: 01/01/1997*
M2	**Not paid separately when the patient is an inpatient.** *Start: 01/01/1997*
M3	**Equipment is the same or similar to equipment already being used.** *Start: 01/01/1997*
M4	**Alert: This is the last monthly installment payment for this durable medical equipment.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
M5	**Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.** *Start: 01/01/1997*
N193	**Alert: Specific federal/state/local program may cover this service through another payer.** *Start: 02/28/2003 | Last Modified: 11/01/2015* *Notes: (Modified 11/1/2015)*
N194	**Technical component not paid if provider does not own the equipment used.** *Start: 02/25/2003*
N195	**The technical component must be billed separately.** *Start: 02/25/2003*

Remittance Advices – 835s

- During the posting process it is important to make sure that all associated account level CARC & RARC codes are used. This will allow for a more accurate tracking and trending of payer responses at the claim level

- Paper remit posting manually completed by staff should be done using the same elements when it comes to remit codes

- At a minimum, an annual review of your CARC & RARC codes should be performed. Depending upon your Host system and how you are set up, it is important to review all settings (general, financial class or by unique remit format template). When was the last time you reviewed these

Remittance Advices – 835s

Do you have mapping set correctly regarding how your system handles the account once posting occurs

- ✓ Money moving correctly to next payer or patient
- ✓ Balances writing off to contractual
- ✓ Suspending the balance for review
- ✓ Driving a denial workflow, etc

(Informational, Contractual, Denial, etc.)

***Automation within posting can be a blessing and/or a curse**

- The curse: Having a code mapped incorrectly to an automatic write-off could be causing a revenue loss. It could be hiding within a contractual adjustment but be a valid denial that needs to be appealed or refiled
- The blessing: Having a code mapped properly to perform accurate and automatic functions

Sample remit detail

Rev	Service Dates	Qual	Code	Mods	APC	APG	Qty	Submit Chgs	Paid Chgs	Group	Code	Amount	LQ Remark
0258	10/17/24	NU	0258				1	90.00	70.20	CO	45	19.80	
0300	10/17/24	HC	36415				0	60.00	0.00	CO	97	60.00	N19
0301	10/17/24	HC	80053				1	90.00	70.20	CO	45	19.80	
0305	10/17/24	HC	85025				1	69.00	53.82	CO	45	15.18	
0330	10/31/24	HC	G0463				0	334.00	0.00	CO	16	334.00	M51
0335	10/17/24	HC	96413				1	1331.00	1038.18	CO	45	292.82	
0636	10/17/24	HC	J9271				200	27762.00	21654.36	CO	45	6107.64	

CAS Code

CO-16 Claim service lacks information or has submission billing errors

CO-45 Charges exceed fee schedule/max allowable

CO-97 Benefit for this service is included in payment allowance

LQ Remark

M51 Missing/incomplete/invalid procedure code(s).

N19 Procedure code incidental to primary procedure.

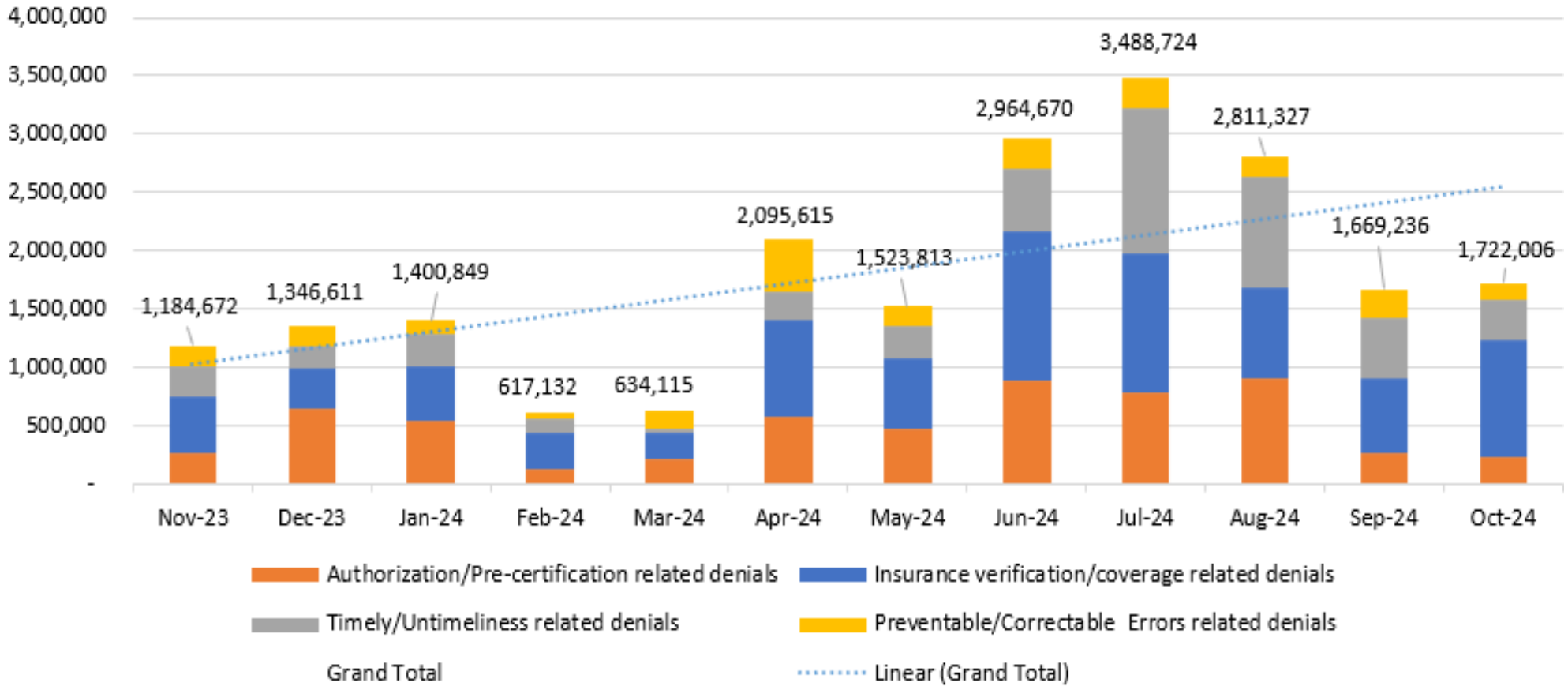
Paper processes can also be unmanaged and become a black hole, hiding issues that you are not aware of

Many have worked to move things to a centralized electronic format (sometimes within a shared drive or even a special software) but everyone still isn't there. And let's face it, there will also be paper to deal with. Tracking in-coming paper correspondence (mail, fax, etc.) is imperative to making sure that accounts don't become denials due to requests not being responded to timely.....or at all

Tracking each category is recommended due to the varying timelines and departments involved to fulfill the needs of the request

- Medical Records (complete or partial)
- Itemized Statement requests (high $)
- Refund requests
- Audit request (these come in various forms and often under different names due to vendor usage by payers)
- Level of Care notifications (IP/OBS, ER down-coding)
- ADRs (Medicare) pre/post payment reviews
- The list goes on and on.....

Creating categories with specific CARC codes will allow for trending and will help determine what needs to be prioritized and addressed for reductions in future denials



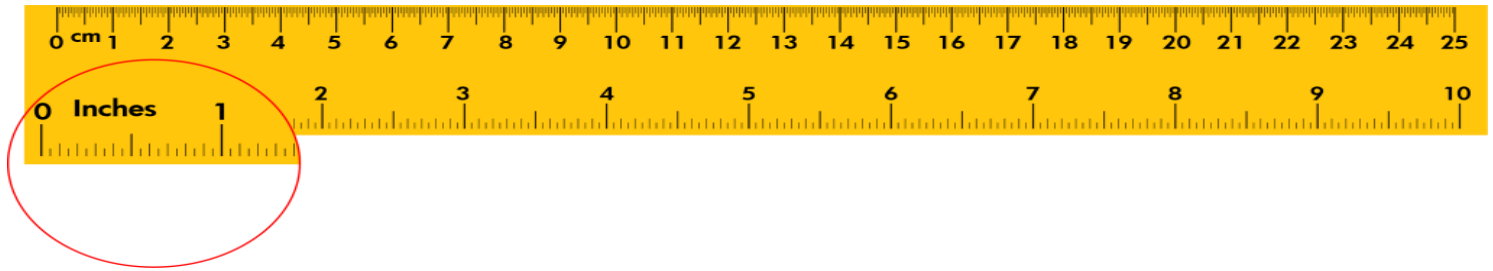
This gives you specific targeted areas that need to be reviewed and worked for future improvements

Revenue Cycle - Teamwork

- A Revenue Cycle Steering committee is highly recommended
- A multi-disciplinary approach is favorable due to the complexities faced; adhoc members as needed
- Regular set agendas with an organized approach to items for review
- Realistic and meaningful expectations should be set for all areas that are identified with areas of improvement
- Set the stage for areas of concern and what challenges are ahead
- Work hard during the tough times but don’t forget to celebrate the wins as they come
- Everyone has a hand in the success or failure of your goals

Key Performance Indicators

- ❑ Are you measuring the necessary KPIs
- ❑ Are you using Industry Best Practice KPIs to compare your operations with
- ❑ What are your action items to the KPIs that are not where they need to be
- ❑ Suggested areas (minimum) that should have KPIs regularly reported and reviewed for improvement opportunities
  - ❖ Patient Access (Scheduling, Pre-registration, Registration)
  - ❖ Utilization Review
  - ❖ Coding (HIM)
  - ❖ Patient Accounts (Billing/Collections/Cash Posting)
- ❑ A standardized cadence should be set to report and share all tracked KPIs
- ❑ Cross-sectional sharing of KPIs help drive better understanding of operations. It also holds people accountable and can even build a healthy competitive environment



Let's discuss Proactive!

Patient Access

What are the items you have an opportunity to do right the first time

- ✓ Scheduling
  - ❑ Is the order accurate and complete
  - ❑ Did you capture all insurance information
  - ❑ Did you verify insurance eligibility and make sure that COB is correct, if needed
  - ❑ Do you have guarantor information identified properly
  - ❑ Does the test meet medical necessity based upon the diagnosis provided
  - ❑ Does the test/procedure require prior authorization? What about implants and special high-cost drugs
- ✓ Pre-registration/Registration
  - ❑ Depending upon the situation, all things listed above can apply
  - ❑ In addition, ER visits and walk-ins can have various but same or similar needs
  - ❑ Did you make the patient/guarantor aware of their estimated OOP during the Pre-reg process
  - ❑ Did you try to collect the OOP that is due from the patient/guarantor during the check-in process

*Some of the largest categories of denials relate to lack of proper insurance identification, incorrect or missing authorizations, along with timely filing limitations that vary from payer to payer

EDI – 270/271
EDI - 278

Let's discuss Proactive!

Utilization Review/Coding

What are the items you have an opportunity to do right the first time

- ✓ Utilization Review (IP & OBS)
  - ❑ Is the order accurate and complete
  - ❑ Are you working closely with the provider(s) to determine the appropriate status? How are you tracking and managing LOC problems with payers
  - ❑ Does the UR team have adequate training/knowledge/skills on various payer methodologies used
  - ❑ Is UR staff having to double check insurance validity due to gaps in the registration process
  - ❑ Do you have a clear workflow regarding status changes? Ie. Inpatient to OBS and authorization requirements
- ✓ Coding
  - ❑ How well is the front-end receiving complete and accurate outpatient orders
  - ❑ Do you have CDI or education given to providers to assist with clear and complete clinical documentation
  - ❑ Are you monitoring unbilled accounts based upon services lines and provider
  - ❑ Do you have workflows that allow coders to be efficient and effective while maintaining a high level of accuracy

*These two areas play pivotal roles in downstream activity that can cause rework or even denials if things aren't handled correctly from the beginning. Moving accounts into active A/R status too quickly will only cause more rework and potential lost revenue

If it's not documented, it didn't happen

Let's discuss Proactive!

Patient Accounts

What are the items you have an opportunity to do right the first time

- ✓ Billing
  - ❑ How robust is your internal **host** system for catching simple errors made up-stream? Do opportunities exist to enhance edits to catch and clean things prior to claim submission
  - ❑ Do you have a process to help keep late charges/credits under control
  - ❑ Are staff more worried about getting claims out the door (speed) versus accuracy of claims (quality)
  - ❑ How robust is your **clearinghouse** for catching more sophisticated errors and bringing them to your attention in a clear and concise manner
  - ❑ Are payer rejection reports being worked timely and is the feedback being provided to those areas that could have done something differently to avoid any of these issues? Is there communication to close the loop so repeated mistakes aren't made
  - ❑ Are staff able to work outside of their job responsibilities to edit/modify claims as they want to help "fix" the claim so it will pay How do you monitor and manage this
- ✓ Collections
  - ❑ Are staff assigned to A/R categories and volume appropriately
  - ❑ Due to the complexities of how payers can differ, are staff educated, trained and held to a standard
  - ❑ Are staff focused more on productivity versus quality
  - ❑ Are first-pass denials easily and clearly identified upon posting of remits
  - ❑ Do staff have defined workflows as to what denials are worked and how they are to be tackled? Are they allowed to go rogue or is this controlled

*Inefficient billing operations can occur when limited communication and feedback isn't provided to help address issues. Manual work and rework can be very common which is frustrating for A/R staff

EDI – 276/277
EDI – 837

Let's discuss Proactive!

Additional areas

What are the items you have an opportunity to do right the first time

- ✓ ChargeMaster (CDM)
  - ❑ How up-to-date are you keeping your CDM
  - ❑ Expired codes or replacement codes, if overlooked, can cause unnecessary rework
  - ❑ Regular reviews and education with clinical departments leads are vital to ensure they understand how to charge and if all services are built and captured within the CDM
- ✓ Insurance Contracting and Managed Care
  - ❑ Do you have a payer matrix to help with the most common payers and their payment structures and methodologies
  - ❑ When was the last time you reviewed your contracts for viability and performance
  - ❑ If available, are you using any contract modeling software to help identify payment variables
- ✓ Payer Credentialing
  - ❑ How well are you managing the on-boarding of new providers
  - ❑ Do you have a streamlined workflow to help assist with tracking claim volume and $ that will drive discussions with payers

*A proactive approach to on-boarding new providers, revalidating and meeting updated credentialing needs for existing providers is challenging. You can do all of this correctly but still be at the mercy of the payers and their cohorts to load your providers timely and accurately. A monthly or quarterly meeting is recommended to have with your top payers to help escalate payer credentialing matters and to hopefully help avoid unnecessary denials or rework

Communication – The Golden Key

Have you ever stopped to think about how well you DO or DO NOT communicate to those you work for, as well as to those that work for you

- Open dialogue between leaders and staff is critical
- Taking time to listen to staff provides them with a sense of caring and builds trust
- Effectively communicating involves not only delivering a message clearly but will resonate with the experiences, values, and emotions of those listening
- Continuous end-to-end education gives the opportunity to explain the importance of each job
- Consistent sharing of KPIs also allows for knowledge growth for the staff and can often spurs competitiveness. Having goals, actively working on them and talking them up can create energy and excitement
- Cheerleading/Celebrating wins are always a boost for morale
- Accountability/coaching and tough discussions are necessary to move the dial on low-performers

Leveraging What You Have

How do you view and use the tools and resources you have

- Often, system capabilities are unknown, under-utilized, or mysteries as to what they can do
- They can also be used as the “reason” or “excuse” for why certain things CAN’T be done within the operations of the Revenue Cycle
- Some will find themselves defaulting to manual processes unnecessarily. Don't fall into this trap
- Ask questions, expect more
- Think outside the box
- If your current tools don’t offer what you need, what are the considerations you need to make to get things done

Opportunities to improve with Technology sources

Moving the needle on technology should be done with a few considerations

- Are the current technology solutions being used to their fullest capabilities
- How often do you speak with your partner(s) to understand the present functionality as well as what they are doing with new technology (ideas or future roll-outs)
- When was the last time you reviewed the gaps within your Revenue Cycle to assess what is still needed that isn't available within your existing product(s)

AI is not just a buzzword anymore. It has taken the payer segment by storm. Payers are using it in many ways to deny claims and/or cause payment delays for providers

Many providers are behind on utilizing AI, as it can seem daunting and overwhelming. Partners are in the marketplace to share and provide support on how to better understand and implement AI in things such as:

- ✓ Writing appeals letters that are specific to clinical documentation within the EMR
- ✓ Helping clinicians make decisions due to results from tests
- ✓ The automation of "suggested" coding
- ✓ Simple-visit and Real-Time coding
- ✓ Insurance discovery and authorization detection requirements
- ✓ Analyzing historical data to predict issues/trends for the future

AI will provide opportunities for greater efficiencies and accuracy within the healthcare arena but human judgement will continue to be needed

Appeals, Reconsiderations or Rebills

Prior Authorization denials (ie CO-197)

Investigate the validity of the denial. If the denial is invalid, provide documentation (authorization number, approval letters obtained online or via mail, initial calls made with reference numbers, etc). Normally, invalid prior authorization denials can be handled by making a call to the insurance company to request reprocessing of the claim. If the denial is valid and an authorization was not obtained then the likelihood of overturning by disputing the denial is futile. If an authorization was obtained but the procedure/test was modified from what was originally approved, some ability to overturn the denial is questionable

Medical Necessity denials (ie CO-50)

Medical necessity appeals are often overturned with the patient's medical record. Do not fall into the habit of sending the entire record. Depending upon the service provided, only certain elements should be shared as part of the appeal. Make sure that your appeal letter is detailed and tells the clear story of what happened with the patient during their episode of care. If the initial appeal denial is upheld, seek advice from additional knowledgeable resources to determine if a level II appeal is warranted

Appeals, Reconsiderations or Rebills

Underpayments/Low/No-pay – These could be the result of a few things

- **Payer error** - When this happens, it is important to know your contracts and how the payer is supposed to reimburse. Provide contract language when applicable to warrant your appeal & reconsideration
- **Charging error** - Departments might have missed charging for services provided or charged incorrectly. The CDM (Charge Master) might not be up-to-date with current hcpc/cpt codes and/or pricing
- **Billing error** – Due to the complexities of UB/1500 billing with various payers, billing operations can often overlook specific payer guidelines that can create certain services to go unpaid or underpaid. Bundling and unbundling are common issues found, along with missing or incorrect modifier usage, missing taxonomy codes, etc

Miscellaneous denials - These are generally not needed or advised due to the length of review time from the payer and their lack of response. These denials can often be overturned by investigation of root cause and a corrected claim resubmitted

***Keep in mind: All denials do not warrant an appeal**

Become proficient at the basics and then build upon that foundation

It takes a village

(TEAM)

- Multi-disciplinary
- Focused Revenue Cycle committee w/ adhoc members
- Clear agendas and timelines
- Prioritized and meaningful expectations (be realistic)

Data and analytics

(The Story)

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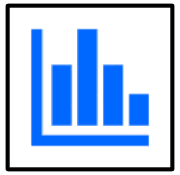

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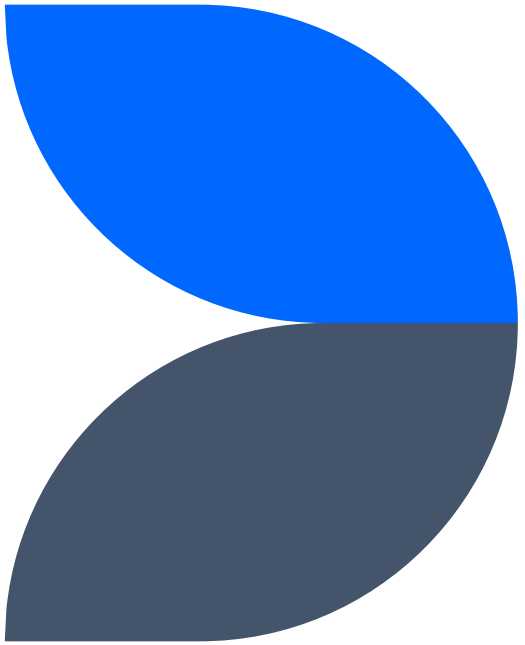
“Tell me and I forget
Teach me and I remember
Involve me and I learn”

Benjamin Franklin

Final tips & takeaways

- Time is of the essence
- Work to be proactive and less reactive
- Strengthen your knowledge of payer trends
- Seek win/win solutions
- Understand that things are constantly evolving. Be adaptable and willing to make changes as necessary
- Not everything is worth fixing, move on

Q&A



Thank you

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