CorroHealth

Denials Management and Prevention

TxHIMA25
Annual Conference

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Discussion Points

Impact of Denials

Strategies:

- Data & Root Cause
- Review Workflow
- Accurate and Complete Documentation
- Robust Appeals Process
- Monitor, Track, Report
- Education and Training
- Continuous Process Improvement

Impact of Denials

- **89%** of all hospitals have seen a significant **increase** in denied claims[1]
- **Commercial insurers** denials have increased on average of **20.2%**[2]
- **Medicare Advantage** claims denial up to **55.7%**[2]
- Providers spent **$20B** in 2022 pursuing delayed and denied claims from payors
  - Average of **3 rounds of reviews**; 45-60 days each round
- **15% of hospital claims are initially denied.**
- **90% of denied claims are preventable**[3]
  - **35%** of providers appeal denials even though **66%** of denied claims are **recoverable**[3]

1. Report: The State of Claims 2022, Experian Health (www.experian.com/healthcare/resources-insights/thought-leadership/white-papersinsights/state-claims-report)
2. RCM Admin Tasks Driving Up Costs. Payer Tech to Blame, HealthLeaders, September 16, 2024
3. Success in Proactive Denials Management and Prevention, HFMA, May 1, 2021

Update: 2024 Data

- Initial denial rate on claims increased to 11.8% in 2024—a 2.4% increase from the year before.
- Rate of denials due to prior authorization declined by 7.7.
- Denials related to questions of medical necessity and requests for more information increased: medical necessity 5.0% increase; request for more information up 5.4%.
- AR days increased 5.2% year over year.
- Providers collected about $3 less in 2024 for every $100 that insured patients on their portion of the bill.

Top causes of denials*

*Experian Health survey 2024

46%

Missing or inaccurate data

Followed by:

- Authorizations: 36%
- Patient information inaccurate/incomplete: 30%

Others:

- Coordination of Benefits (COB)
- Coding errors
- Staff shortages
- Poor training
- Missing Coverage
- Payer policies
- Timely filing

Impact of Denials

Survey says…..

66% reported denials occur at higher rates than before the pandemic

65% state that submitting clean claims is more complex than ever before

84% said that reducing denials is a priority for the organization

Factors for the Increase In Denials

- **Payer policy changes occurring more frequently**
- Lack of denials resources
- Staff attrition and training
- Growing denials backlog
- Pre-authorization tracking
- Technology challenges

Strategies

Data, Data, Data…

- Using denial data to identify root cause is critical
- Document and trend the reasons for denials
- Identify patterns and trends

Identify the Root Cause(s)

Create a Multidisciplinary Team

- Coding
- Patient Access
- Utilization Management
- Managed Care
- Revenue Cycle
- CDI
- HIM/Coding
- Legal
- Compliance
- *Physician Liaison*

Review Workflow

Scheduling
- Authorization
- Medical Necessity

Patient Access
- Authorization
- Patient information accurate
- Covered service

Patient Care
- Physician documentation; CDI
- Medical Necessity

HIM/Charge Capture
- Documentation
- Coding

Billing / Patient Accounts
- Bundling
- Timely filing
- Coordination of benefits

Accurate and Complete Documentation/Coding

Denials Prevention – Coding

Code to the highest level of specificity

- Capture acuity by coding CCs and MCCs according to the updated coding clinics and coding guidelines
- Look for missed documentation opportunities
- Focus on DRGs with CC's and MCC's
- Productivity is important, but quality is key

Develop a robust query process to prevent under-coding

- Quality queries based on ACDIS query guidelines

Appeals

Appealing Denials

Need a strong denials team to write the appeals letters

85-88%

is the recommended appeal rate

Denials Requiring Appeal

Days, service level of care denied for no concurrent authorization

Claim denied for elective service without pre-authorization

Not a covered service

Charge/procedure as bundled

Timely Filing

Tips to Writing Appeal Letters

- Appeal every case where there is documentation to support the original coding
- Keep the appeal letter concise to the reason for the denial

- Include Clinical and Coding Expertise to write the appeal
- Include the pertinent record excerpts that support the appeal

- Include copies of the medical record where helpful

- Include official coding guidelines

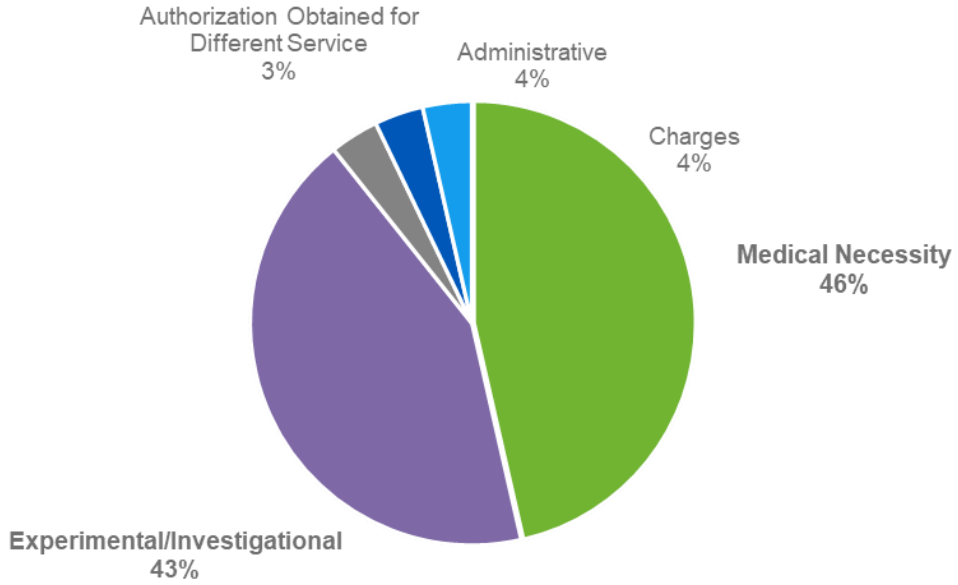
- Include the credentials of those who have reviewed and are involved in the appeal

Monitor, Track, Report

Monitor, Track and Report

- Total denials
- Total appeals
- Cases not appealed and why
- Total cases overturned and financial impact
- Second-level denials
- Failed appeals

Monthly Clinical Denials



Denial Reason	Total # Accts	Acct Balance	% of Total Denials	% of Acct Balance
Medical Necessity	13	$58,512	53%	46%
Experimental/ Investigational	12	$44,570	41%	43%
Authorization Obtained for Different Service	1	$4,187	4%	4%
Administrative	1	$1,287	1%	4%
Charges	1	$1,113	1%	4%
Grand Total	28	$109,668	100%	100%

Education, Training, Continuous Process Improvement

Educate, Train, Report

…and Continuous Improvement

- Regular coding audits
- Review denials analysis data
- Work together
- Education – Physicians, Coders, Billers
- Collaborate with Payors
- Use the PEPPER report to proactively compare performance to other facilities
- Engage in continuous process improvement

Next Level - Management to Prevention

Transition to denial prevention for the denials that can’t be overturned

- Departmental training
- Engage clinical staff
- Build out front-end edits to stop denials before admission or service
- Implement technology to combat denials pre-billing

In Conclusion

Ongoing communication and collaboration

Consistent and timely review of denial data

Successful appeals letter writing

Questions?

Thank you for y our time

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- Success in Proactive Denials Management and Prevention, HFMA, May 1, 2021
- Coding Denials: Effective Appeals HFMA March 1, 2021
- Denials Management: Getting to the Root Cause, Denise Wilson & Tracey A. Tomak, November 2019
- The State of Claims, 2024 Survey, Experian Health, June 2024
- RCM Admin Tasks Driving Up Costs. Payer Tech to Blame, HealthLeaders, September 16, 2024
- Mastering Denial Management Tactics for Maximizing Reimbursements, Medwave, March 14, 2024

Your Partner for Clinical Revenue Cycle Management

Seamless strategies to align patient care, operational efficiency, and financial health.

FRONT END

Patient Experience

- Registration & Scheduling
- Insurance Eligibility & Authorization
- Financial Counseling

Chargemaster Services

- Market-Based Pricing
- Chargemaster
- Price Transparency
- No Surprises Act

MID CYCLE

Utilization Management

- Admission Status Reviews
- Physician Advisors
- Peer-to-Peer Reviews
- Analytics as a Service

Clinical Documentation

- Inpatient CDI
- Outpatient CDI
- HCC Coding & HEDIS Abstraction
- Provider Education

BACK END

Coding

- Coding Automation
- Outsourced Coding
- Coding Audits and Education

Claims Management

- Billing & Claim Edits
- AR Management & Follow-Up
- Specialized AR
- Payment Posting Reconciliation
- Self-pay

Denials

- Denials Prevention
- Denials Management
- DRG Downgrades
- Transfer DRGs

Value-Based Care

- RAF Accuracy
- Risk Adjustment Program
- VBC Strategy & Action Plan

Technology

- PULSE Coding Automation Technology™
- VISION Clinical Validation Technology™
- REVIVE Specialized RCM Automation™
- The Smart App®

CorroHealth

Clinically Led Healthcare Analytics

Intelligent Technology to Improve your Financial Health

300+
MEDICAL DOCTORS & CLINICIANS

200,000+
HEALTHCARE DATA SCIENTIST HOURS

5,000+
INTELLIGENT TECHNOLOGY RULES

$5.7 Billion +
IN COMPLIANTLY RECOVERED REVENUE

CorroHealth is the leading provider of clinically led healthcare analytics and next-generation technology solutions dedicated to positively impacting the financial performance of hospitals and health systems.


CorroHealth