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Denials in the World of ICD-10

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hfma south carolina chapter
healthcare financial management association

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Seth Avery

Mr. Avery has over 25 years of experience as a healthcare executive, serving as auditor, consultant, Administrator and Chief Financial Officer (CFO). Mr. Avery has served as the CFO for a major teaching hospital in Texas and as the Executive Director of a leading New Jersey Medical School. He has worked at government, for-profit, and not-for-profit health care providers, as well as at a Big 6 organization.

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Diane Story

Diane Story is the Director of Revenue Cycle Improvement for Roper St Francis Healthcare in Charleston, SC. In this role, she is responsible for identifying, analyzing, and implementing projects that directly impact cash collections, process improvement, cost reduction and/or revenue generation. Her primary responsibilities currently include Project Manager for the ICD-10 transition and implementation of a Business Process Management (BPM) tool to streamline processes and increase efficiency.

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Agenda

- Introduction
- Background
- ICD-10 and Denials

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How do you get your denials today?

- How does your payer communicate with you?
- Standard data set ANSI 835
- Powerful and complex

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ANSI 835 Basics

- Provides information as to why you were paid what you were paid
- If you were not paid in full or what you were expecting to be paid, there should be an explanation as to why
- Used to communicate the results of your claim to your accounts receivable (A/R) system
- It should tell you the reason for adjustments
  - Contractual (Fee schedule etc.)
  - Benefit limits
  - Patient responsibility

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ANSI 835 Basics

- How is information communicated?
  - A long string of asterisk-delimited characters
- What are you looking for in that data?
  - Payments/Adjustment/Remarks
- Remittance Advice Remark Codes (RARC)
  - ~~777~~ 930
- Claim Adjustment Reason Codes (CARC)
  - ~~233~~ 298
  - Used at the claim and the service level

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Definitions… what is a denial

- Multiple Definitions
- So organizations use the CARC
- HFMA
  - Zero Pay Denial
  - Partial Pay Denial
- Others?

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Definitions… what is a denial

Zero Pay Denial =

- A payer transaction (ANSI 835) which has zero in payer payment (CLP 04) and patient responsibility (CLP05)
- When the balance of a Claim Group ™ nets to, or is less than, zero

Partial Pay Denial = A status indicator of “4” (“denial")

Claim Group =

- Because the same claim can have different claim numbers and each claim number can have many payments and reversals associated with it, we look at them all together as a Claim Group
- These Claim Groups are like a family and sometimes they have a lot of children!

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HFMA MAP KEYS

Initial Denial Rate – Zero Pay

- **Purpose:** Trending indicator of % claims not paid
- **Value:** Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
- **Equation:** $\frac{\text{Number of zero paid claims denied}}{\text{Number of total claims remitted}}$
- **Target:** ≤ 4.0%

Notice the CARC or RARC is not in this calculation.

Do you have Medicare Managed Care "shadow claims"?

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HFMA MAP KEYS

Initial Denial Rate – Partial Pay

- **Purpose:** Trending indicator of % claims partially paid
- **Value:** Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
- **Equation:** $\frac{\text{Number of partially paid claims denied}}{\text{Number of total claims remitted}}$

How do you identify a partial pay?

At AppRev we look for a Claims Status Code of "4" with an allowable amount.

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HFMA MAP KEYS

Denials Overturned on Appeal

- **Purpose:** Trending indicator of hospital's success in managing the appeal process
- **Value:** Indicates opportunities for payer and provider process improvement and improves cash flow
- **Equation:**

$$\frac{\text{Number of appealed claims paid}}{\text{Total number of claims appealed and finalized or closed}}$$

- **Target:** 40.0 – 60.0%

At AppRev we look for a remit that previously qualified as a zero/partial payment that had a subsequent remit with an additional payment.

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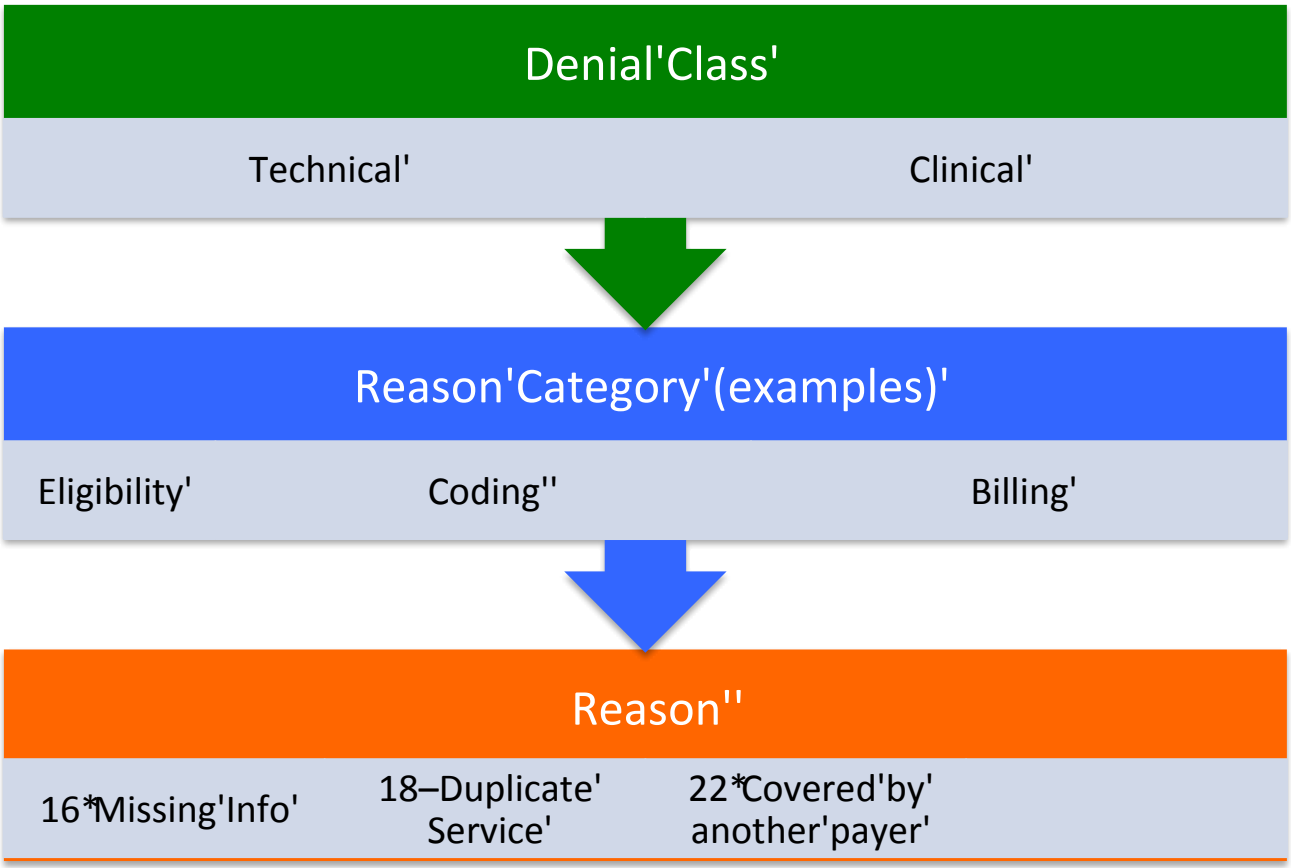
Using Denial Classification



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ICD -10 and Denials

- “If ICD-10 implementation is going to double the typical rate of denials then you better cut them in half now”
- What are your denial rates now?
- Do you track by:
  - Issue?
  - Payer?
  - Dollars?

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ICD -10 and Denials

- Do you know which payers will use ICD-10 on October 1st, 2015?
  - How are you investigating?
  - Are we sharing results?
- Contractual terms driven by ICD-9 diagnosis or procedure codes
- Authorizations
  - Do you have authorizations that are now ICD-9 but when you bill them in ICD-10

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Developing an ICD-10 Denial Plan

- Analyze the behavior of each payer for variables that are currently impacted by ICD-9
- “If it doesn't matter in 9, it won’t matter in 10” - Seth Avery
- Inpatient and Outpatient may be very different
- Develop a flowchart for each payer and you can weed out the ones to ignore
- Once you figure out what matters in 9 you know your risk for 10

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Developing an ICD-10 Denial Plan

Inpatient

- How are you reimbursed?
  - MS-DRG/APR-DRG, Case rate, % of charge?
  - Under a DRG system there is direct impact outside of denials
  - Device/drug carve outs?
- Medical necessity
  - ICD-9?

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Developing an ICD-10 Denial Plan

Outpatient

- Medical Necessity
  - Medical Necessity
  - Medical Necessity
- Specific contract language
  - Cardiac devices and other devices may require specific ICD-9s
    - Have you identified their replacement in 10?

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Managing the transition

- Pre-authorizations
  - Do you have pre-authorizations in 9? Will they turn into pumpkins on October 1st (you pick the year)
  - What data do you use in 9 to track performance and identify issues?

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RSF Denials Background

- We measure two types of denials:
  - **Initial** Denials – all denials received via an 835 file or hard copy EOB.
  - **Final** Denials – denials that we are unable to appeal or lost the appeal.
- Volume and Value (2014):
  - **Initial** Denials – 59,500 denials totaling $277M
  - **Final** Denials – 12,500 denials totaling $9M
    - Medical Necessity: 30.8% of value
    - No Authorization: 21.2% of value
    - Documentation Does Not Support: 15.4% of value

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Denials and ICD-10: Why is it Important?

- CMS estimates that in the early stages of ICD-10 implementation, denial rates will rise be 10 – 200%.
  - RSF had >$9.3M in final denials in 2014, with a cash value of approximately $3M.
  - If denials increase 100%, we have the potential to lose more than $6M.
- Claim error rates are estimated to double with ICD-10.
  - According to our MAP keys, RSF has a clean claim rate of 72.2%.
  - If this estimate is correct, more than half of our claims will not make it through the scrubber.

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Denials Management Program

- FIRST… If you don't have a robust Denials Management Program in place – do it!
- Your Denials Management Program should include (at a minimum):
  - Cross functional denials management committee
  - Detailed and robust reporting to a root cause level
  - Alignment of staff and leadership incentives
  - Workflow technology
  - Leverage physician champion to assist with physician documentation and communication
  - Ensure structure to the program
  - Determine the structure that works for your organization!

Denials Management Program - Charter

No Authorization Denials

Initiative	**Reduce No Authorization Denials**	**Date Submitted**	12/15/2014

Description of Opportunity	An opportunity exists to reduce No Authorization Denials.
Scope & Boundaries	The scope of this charter includes No Authorization Final Denials >$4,000 with dates of service on or after January 1, 2014.
Deliverables	- The Revenue Cycle Improvement department will complete a monthly analysis of No Authorization Final denials greater than or equal to $4,000 (or lower the threshold to get a significant sample size) and send to the denials management team and steering committee (Julie Graudin, Bobbie Maner, Kim Sheldon, Diane Story) by the last weekday of the month. - The Denials Management team will meet to review the detailed analysis, update the work plan and address any new issues by the 2nd Wednesday of the following month. The work plan is due to the steering committee at completion of this meeting. -Review of work plan results with steering committee 3rd week of each quarter. -High Level Review at Revenue Cycle Workgroup 2nd Thursday of Month.

Initiative Team

Name	Title	Department
Jacklyn Carter	RCI Analyst	Revenue Cycle Improvement
Anita Agbonhese	Dir Pre-Services	Scheduling
Janel Crotty	Coord Pre-Services	Schedulinig
Lila Elshazly	Coord Pre-Services	Scheduling
Ellen Manus	Coord Pre-Services	Scheduling
Connie Small	Supv Patient In-take	Financial Counseling

Action Plan

Key Milestones	End Date	Work Product
Engage Team Members	12/15/2014	Charter, Work Plan
No Authorization Denial Analysis	Last weekday of month	Detailed Analyses by rootcause
Workgroup Meeting	2nd Wednesday of Month	Update Work Plan/Action Items
Steering Committee Meeting	3rd Week of each Quarter	High Level Issues and Action Plan
High Level Review at Revenue Cycle Workgroup	2nd Thursday of Month	High Level Issues and Action Plan

Success Criteria/ Metrics

Metric	Target	Actual
No Authorization Final Denial Baseline volume 117 accts/mo	10% reduction 6 mo	
No Authorizaton Initial Denial Baseline volume 230 accts/mo	10% reduction 6 mo	

Risks

Risks to meeting this initiative
1 Competing priorities.
2 Outstanding FTE's.
3 Technology-system limits and inabilities.
4 Volume--need to flex staff.
5 Understaffed

Stakeholder Review

	Acceptance Signature	Date
Project Manager	Jacklyn M. Carter	
Executive Sponsor	Julie Graudin	
Quality Sponsor	Suha Malhi	

An opportunity exists to reduce No Authorization Denials.

Accountability

- The Denials Management team will meet to review the detailed analysis, update the work plan and address any new issues by the 2nd Wednesday of the following month. The work plan is due to the Steering Committee at completion of this meeting.
- Review of work plan results with steering committee 3rd week of each quarter.
- High Level Review at Revenue Cycle Workgroup 2nd Thursday of Month.

10% reduction in initial and final denials.

Measurable Targets

Recognize the Risks and Barriers to success.

Risk Mitigation

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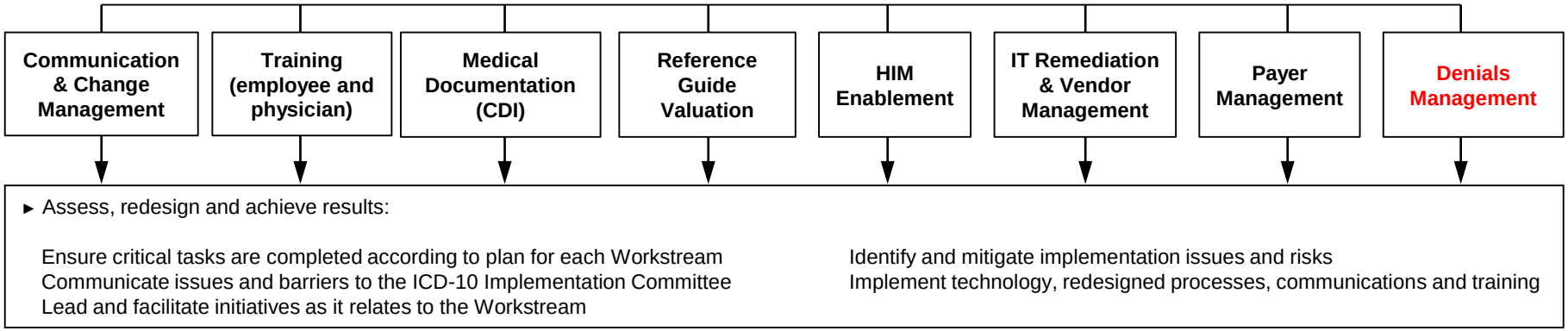
ICD-10 Project Management

- Make denials a key part of your ICD-10 readiness planning.

RSF ICD-10 Workstreams:



ICD-10 Project Management - Workplan

Denials Workstream Workplan Milestones (Major)

- Complete denial analytics baseline metrics
- Evaluate and remediate gaps as required
- Implement remaining payors on 835
- Establish a flexible staffing model to prepare for an increase in total denials volume
- Establish a team to accelerate cash primarily by working denied accounts
- Analyze resolution rate by Remittance Advice Code to determine how to prioritize follow-up
- Actively communicate all denial activity to key process owners
- Track denial benchmarks
- Develop a dashboard to track the top denials impacted by ICD-10
- Align targets with staff incentives and organization of the denials program
- Create a cross-functional denials management committee that meets bi-weekly
- Evaluate denial experience as a result of end-to-end testing
- Evaluate results and monitor progress (weekly)
- Gather feedback (quarterly)
- Update denials management strategy and plan, as needed (monthly)

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ICD-10 Project Management - Scorecard

- Create an ICD-10 Scorecard that includes denials:

# Systems ICD-10 Compliant	% Coders Meeting Productivity Goal	Cash as a Percent of Net Revenue
# Reports Remitted/ICD-10 Compliant	**Coding Quality- Inpatient**	Days Discharged Not Coded / Billed
# Interfaces and Data Extracts Compliant	**Initial Denial Percent - Hospital**	% Patients Reviewed by CDI
# Payors completed end-to-end testing	**Initial Medical Necessity – Hospital**	Physician Response Rate to Queries (CDI)
Gross Days in Accounts Receivable	**Initial Non Covered - Hospital**	% Accuracy Between Working and Final DRG
Payments Received > 90 Days from Submission	**Initial No Authorization - Hospital**	% Guides for Coverage Determination
Percent Clean Claims	**Initial Denial Percent - Physician Partners**	% Training Level Deadline Met

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Understand Your Denials!!

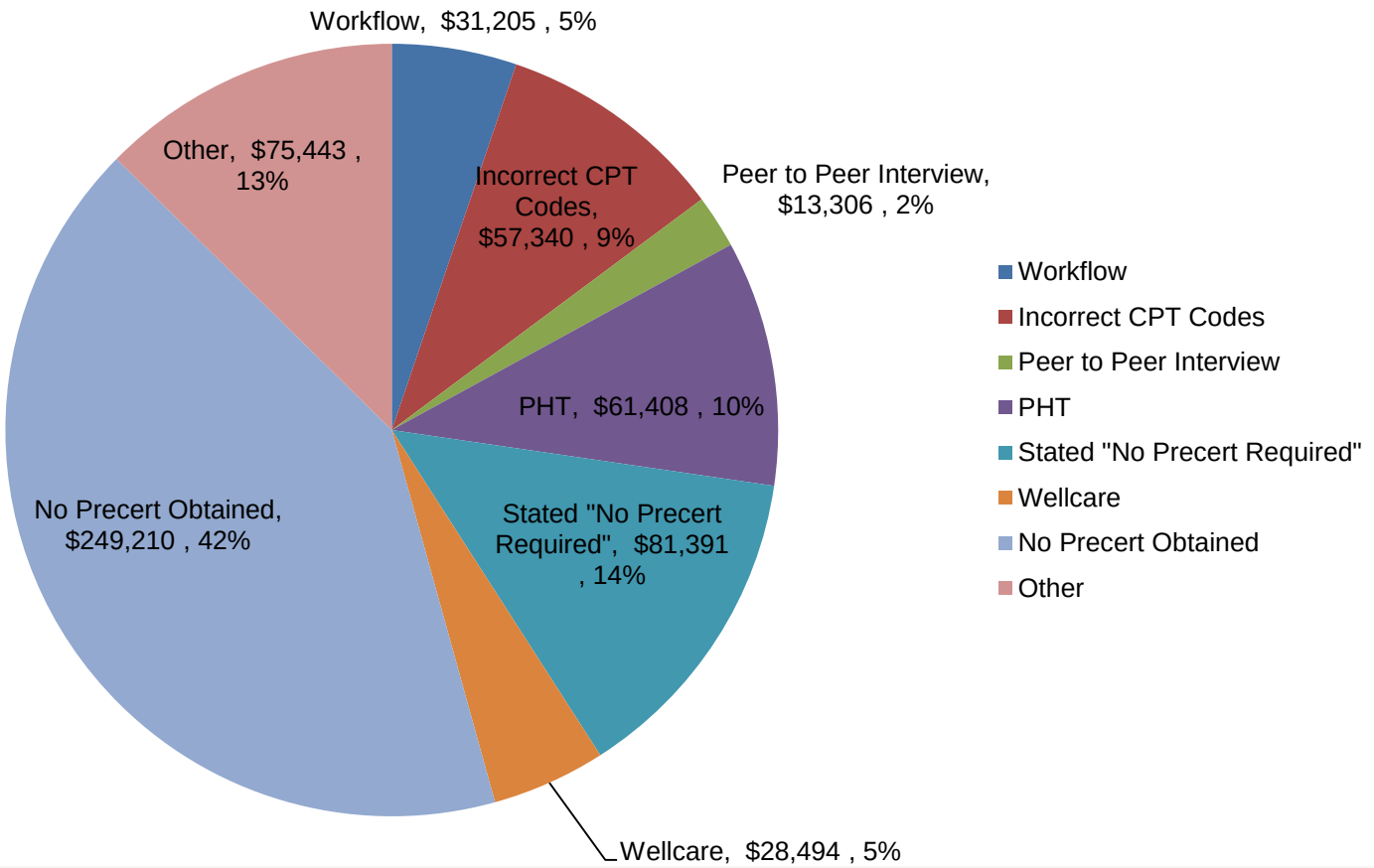
2014 Denials Impacted by ICD-10

Denial Reason	CARC	Total
Additional Information Required	252	$40,907,129
	16	$22,151,788
	227	$6,878,339
	226	$1,439,157
	251	$878,363
	107	$818,490
	129	$68,817
Additional Information Required Total		**$73,142,081**
Non-Covered Service	96	$17,276,729
	46	$369,142
	55	$257,005
Non-Covered Service Total		**$17,902,875**
Invalid/ Missing Diagnosis	167	$5,424,407
	146	$662,905
	11	$436,223
	10	$190,182
Invalid/ Missing Diagnosis Total		**$6,713,716**
Medical Necessity	AUDIT	$3,258,113
	50	$2,451,046
	40	$259,852
	B8	$69,463
Medical Necessity Total		**$6,038,474**
Invalid Proc/Rev Code/Modifier	182	$768,769
	181	$709,220
	4	$626,706
	6	$522,529
	B15	$268,432
	199	$67,990
	5	$51,998
Invalid Proc/Rev Code/Modifier Total		**$3,015,643**
Invalid Coding	234	$210,396
	65	$40,202
	230	$23,018
Invalid Coding Total		**$273,616**
Unbundled Service	49	$135,439
Unbundled Service Total		**$135,439**
Grand Total		**$107,221,845**

- What is your denial experience for the denials that are expected to be most impacted by ICD-10?
  - 39% of our denials are estimated to be impacted by ICD-10.
  - Potential cash impact of $35M.

Understand Your Denials!!

- Complete a detailed denial analysis of your key denials (“deep dive”).



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Understand Your Denials!!

- Complete a root cause analysis.

ROOT CAUSE ANALYSIS - DECEMBER 2014		
Coordination of Benefits	**472**	**Percent**
Secondary Processed Correctly	189	40.04%
COB / Other Insurance Primary	85	18.01%
ESRD-Overlapping Dialysis Treatment Dates	54	11.44%
Claim Data / Billing Error	53	11.23%
Not a Covered Service / Procedure / Charges	13	2.75%
Primary EOB Requested	12	2.54%
Root Cause (See Notes)	8	1.69%
Payor Error in Claim Adjudication	8	1.69%
Account Requires Rebill	6	1.27%
Duplicate Claim	5	1.06%
Other	39	8.26%

Additional Information Required	**730**	**Percent**
COB / Other Insurance Primary	173	23.70%
Accident Form Requested from Patient / Guarantor	150	20.55%
Claim Data / Billing Error	78	10.68%
Primary EOB Requested	45	6.16%
Info Requested from Patient / Guarantor	44	6.03%
Medical Record Requested	39	5.34%
Not a Covered Service / Procedure / Charges	28	3.84%
Units of Service	14	1.92%
Payor Error in Claim Adjudication	14	1.92%
Invalid / Inappropriate Diagnosis	13	1.78%
Rebill Required: Lab Only	12	1.64%
QA-COB Letter Sent to Patient per CBO	11	1.51%
Account Requires Rebill	11	1.51%
SAD - Self Admin Drugs/Patient Responsibility	8	1.10%
QA-See Notes In Star	8	1.10%
Primary Paid More Than Secondary Carrier Allowed	8	1.10%
Other	74	10.14%

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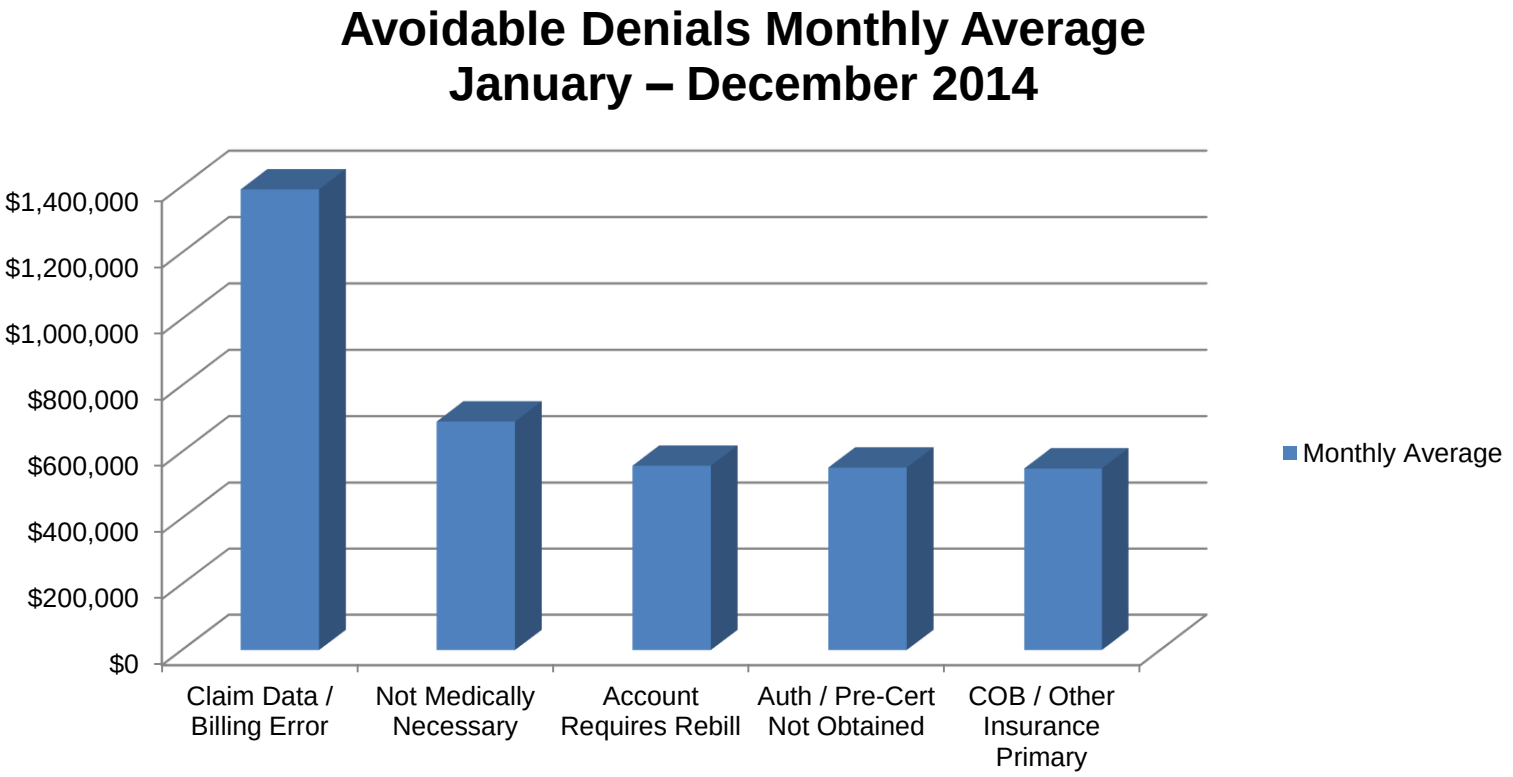
Understand Your Denials!!

Denial Type	Issue	Action Plan	Responsible	Status	Date Reported	Completion Date
No Authorization	Pre-cert obtained for the incorrect CPT/HCPCS Code	Create an exception report that shows the Authorized codes and the actual codes by Louise's group. If an exception, this is fed back to pre-services to update authorization prior to bill dropping. If denials continue feed this information back to managed care for contract negotiations.	Jackie	12.17.14 Wrote to Susan Tilman about using a field in STAR to store the CPT code authorized. 12.16.14 Asked Anita for an IT contact for her area to identify if we can add a field in STAR that would capture the authorized CPT code.	12/16/2014	
No Authorization	Pre-cert obtained for the incorrect CPT/HCPCS Code	Develop a process to pass CPT/HCPCS code from scheduling work list to pre-services.	Jackie	12.15.14 Per Suha, General Surgery order forms to include CPT codes but this is not required. 12.3.14 I spoke to Suzanne Frizelle and she commented that they don't receive CPT/HCPCS codes often (less than 50% of the time). She commented that the new standard orders sent out to the offices don't have a field for this information and when she reached out to offices they commented that it wasn't their responsibility and that they didn't know this information at hte time of scheduling.	11/14/2014	
No Authorization	Out of network with wellcare 210009	Build Alert for pre-services to note that ALL services require prior authoriztaion.	Doug	12.16.14 delte rule once we are in network with Wellcare. 11.19.14 Jackie sent request to Doug Lind. Doug activated AhiQa rule to alert staff that we are out of network with 210009 and that ALL procedures require prior authorization. Alert written for IV, Pre reg, and practice works team. Per Doug Access will not see this rule.	11/14/2014	11/19/2014
No Authorization	Obtaining subsequent authorizations for Physical Therapy Patients	Identify a tracking mechanism to know when an authorization is required for subsequent visits.	Jackie	12.15.14 Jackie to pull annualized denial report to share when we meet with department early next year.	11/14/2014	

Understand Your Denials!!

- Identify avoidable denials and develop an action plan to minimize/prevent.



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Complete a Staffing Analysis

- How will you manage increased volume?

	Current State of Denials					Future State of Denials					
						Estimated Volume Increase/Estimated FTE(s) Increase					
Denial Description	Average Monthly Activities*	Avg Time to Work an Account (min)	Avg Time to Work Current Volume (min)	Staff Monthly Productivity** (min)	Required FTEs	25% ↑ accts	FTE(s)	50% ↑ accts	FTE(s)	75% ↑ accts	FTE(s)
Pt Not Eligible	285	15	4277	8228	0.52	356	0.65	428	0.78	499	0.91
Additional Info Required	1141	8	9131		1.11	1427	1.39	1712	1.66	1998	1.94
COB	399	8	3192		0.39	499	0.48	599	0.58	698	0.68
Incomplete Insurance Verification	310	15	4654		0.57	388	0.71	465	0.85	543	0.99
Duplicate	227	25	5668		0.69	283	0.86	340	1.03	397	1.21
Billing Error	180	15	2696		0.33	225	0.41	270	0.49	315	0.57
Invalid/Missing Diagnosis	23	15	343		0.04	29	0.05	34	0.06	40	0.07
Inadequate/Missing Documentat	105	20	2091		0.25	131	0.32	157	0.38	183	0.44
Provider not Eligible	44	25	1104		0.13	55	0.17	66	0.20	77	0.23
Invalid Coding	8	15	120		0.01	10	0.02	12	0.02	14	0.03
Invalid Proc/Rev/Mod	23	15	347		0.04	29	0.05	35	0.06	41	0.07
Past Timely Filing	64	25	1607		0.20	80	0.24	96	0.29	113	0.34
	2809				4.28		5.35		6.42		7.49

Current denial FTEs: 2.25

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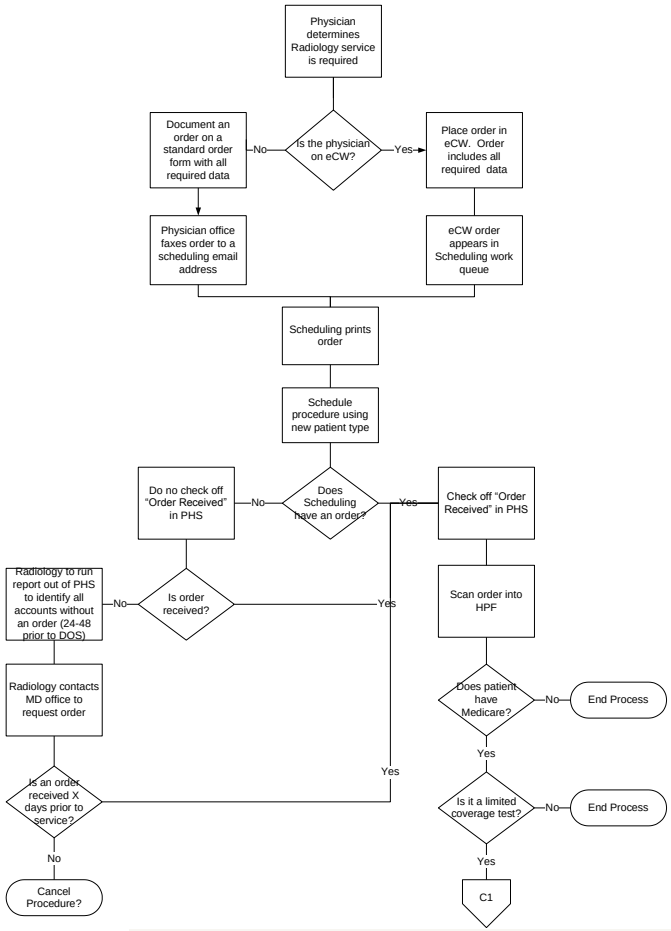
What About Medical Necessity?

- Review your medical necessity process:
  - Started by identifying all areas within the hospitals and physician practices that used cheat sheets.
  - Visited the sites to determine why and how cheat sheets were used.
  - Identified departments that were using cheat sheets to locate diagnosis codes, and inputting them into the system, even though they did not have any limited coverage tests or were obtaining ABNs.
  - Conducted time study on our Coding Hotline.
  - Worked backward from the medical necessity adjustment codes to determine the highest priority departments:
    - Radiology – 40.6%
    - Laboratory – 17.0%
    - HBO – 11.2%
    - OR – 8.9%
    - Cardiac Rehab – 7.3%

What About Medical Necessity?

Radiology Order Process – Ideal State (Scheduled Procedures Only)



- Flow out the current and ideal state processes.
- Do you receive orders timely?
- When will medical necessity checking occur?
- Who is responsible for translating a written diagnosis on the order to an ICD-9 code to check for medical necessity?
- Who will upload all of the new ICD-10 codes into your medical necessity checker (when we finally receive the LCD/NCDs)?

<u>Key features of our Future State:</u>

- Orders for <u>Medicare</u> limited coverage tests will be coded by Coders.
- Accounts will be checked for medical necessity once the order is received and before the patient presents.
- Ordering physicians will be notified in advance if the diagnosis on their order does not meet medical necessity.
- Contact patients prior to presenting if they will have to sign an ABN and pay for their procedure.

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What Else Should You Do NOW?

- Secure a line of credit.
- Implement as many 835 files as possible.
- Work down denial worklists/queues to as low as possible.
  - Conduct a Cash Acceleration Project
- Conduct a(nother) payor survey(s). Inquire about:
  - Questions about testing
  - Trading partners between hospital clearinghouse and payor
  - Reimburse based upon ICD-10 or GEM back to ICD-9
  - Dual processing
  - Additional resources for customer service calls
  - When will they be ready to provide authorizations for ICD-10 procedures

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What Else Should You Do NOW?

- Establish a process for an “ICD-10 Stress Test Day” for CDIs, Coders, Medical Necessity, etc.
- Establish a process for a “war room” for the week surrounding ICD-10 transition
  - Presence in Radiology, Registration, CDI, Coding Hotline, etc.
  - Create process cheat sheets so staff know how to process the ICD-10 codes and where to go for a resource

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Discussion