Charting the Course of Costly Denials

CAHAM 55th Annual Meeting

Becky Cloud-Glaab | September 10, 2024

UCI Health

UCI Health's Mission: Discover Teach Heal

Orange County's Only:

- Academic facility (459 beds)
- Level 1 Trauma Center
- High-risk maternal/ fetal transport program
- Regional Burn Center
- Hematopoietic stem cell/bone marrow transplant

Additional Facts:

- NCI-designated Comprehensive Cancer Center
- Clinical Trials and Research
- 2 Federally Qualified Health Centers (FQHC)
- Comprehensive Stroke Center
- Acquired 4 Community Network Acute Care Facilities (858 beds)
- Physician practices/ASC's/IDTF

UCI Health is Growing!

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<u>WCAC (Opened April 30, 2024)</u>

- Ambulatory Center
- Laboratory/Imaging
- Digestive Institute
- Urgent Care
- Center for Autism & Neurodevelopmental Disorders

<u>WIACC (Opened July 16, 2024)</u>

- Ambulatory Surgery/Procedures
- Chao Cancer Center
- Radiation Oncology
- Retail Pharmacy
- Research

<u>Hospital (Opens December 2025)</u>

- All electric hospital
- 144 bed acute care hospital

Why Focus on Denials?

Disruption to cash flow: Denials slow down cash flow and increase A/R Days

Increased Costs: Working denials requires additional resources and rework; average cost to rework a denial is estimated anywhere between $25-$117 per claim

Effective denials management requires dedicated staff, systems and efficient workflows

Negatively impacts employee morale by working and reworking accounts, even when the team has done everything right

When patients receive copies of denied Explanation of Benefits (EOB), they often perceive it as the provider's fault, negatively impacting their overall patient experience with the provider

Data shows the average denial rate at healthcare providers ranges between 9%-11%

Combatting Denials

Best way to combat denials is to avoid denials

- Deep dive into denials
  - Identify type of denial: Technical vs Clinical
  - Identify avoidable vs non-avoidable (includes root cause analysis)
    - Missing Registration/Pre-cert/Authorization
    - DOB Issue
    - Subscriber can't be identified
    - Coverage not effective for dates of service
    - Out of Network Provider/No OON benefits

Develop a Denials Steering Committee

- Identify key Steering Committee members
  - Admissions
  - Case Management/Utilization Management
  - Scheduling/Authorization Unit
  - IT
  - Patient Financial Services (PFS)
- Develop charter
- Create workgroups
  - Assign roles, responsibilities and deliverable dates

Develop a Denials Management Team

- Denial Teams – Identify roles and responsibilities
  - Lead, committee make-up and reporting teams
- Meeting frequency for Steering Committee - Monthly
  - For guidance, escalation, etc.
- Meeting frequency for Committees - Bi-weekly
- Provide and review analytics
- Report by reason/location/department
- Committee Leads report to Steering Committee
- Track and trend root cause analysis progress
- Develop prevention strategies

Avoiding the Denial: Patient Demographic

Frontend avoidance opportunities: Patient Demographic

- Capturing and documenting complete demographic information is a necessity to avoiding denials
  - DOB mismatch (scan/copy driver's license)
  - Subscriber can't be identified
  - Name of patient doesn't match records
  - Accurate insurance information (scan/copy insurance card)
    - Is the payer the health plan or IPA? (read the card when selecting payer/plan)
  - Employer information
  - Preferred contact source
  - Preferred name

Avoiding the Denial: Eligibility

Frontend avoidance opportunities: Not just eligibility!

- Verify patient eligibility prior to service via RTE, payer websites or contacting a payer via telephone
  - Review benefits obtained, ensuring scheduled/planned services are covered
  - For Medi-Cal/Managed Medi-Cal reverify coverage if service is after the 15th of each month, including inhouse accounts
  - For all payers, if scheduled service is in a future month, verify eligibility and benefits at beginning of service month
  - If a Managed Medicare eligibility returns Hospice, ensure Medicare FFS is listed as payer
  - If Medicare returns patient is in a SNF, be sure to contact the SNF for billing information or update to the CWF

Avoiding the Denial: Pre-Authorization

Frontend avoidance opportunities: Prior Authorization

- Submit all required documentation/information to payer at time of authorization request
    - Notice of Admission must be submitted at time of Admit for all IP Admits
- Know your payer requirements and turnaround times for authorization
    - IPA
    - Health Plan
- EMR payer access, ensure all documents for authorization approval is visible in the EMR
    - Are all notes available at time of payer review (e.g. transcription, physician signed note before release, etc.)
- Know payer guidelines for concurrent denial for inpatient stay, and peer to peer deadlines
    - Optum allows 72 hours with no exception including holidays and weekends
- Remember, authorization is not a guarantee of payment; eligibility and benefits with authorization is required for payment

Avoiding the Denial: Education

- Eligibility and benefit denials lead to rework, surprise patient billing and provider/facility write-offs
- Denial Avoidance is an interdepartmental responsibility and requires training and retraining of admissions, registration, referring physicians, schedulers, case managers, etc.
- Feedback is important: Corrective action doesn't occur without communication and awareness
- Review/Retrain/Refresher education
- Utilize Reglines – Organization wide notices regarding updates, changes, enhancements

UCI Health Sample Regline

REGLINE
TO: All Team Members
RE: Entering Patient Names in Epic & Obtaining updated ID Cards

It is important that all team members are following the same process when entering a patient name in Epic. This process was implemented to decrease the number of duplicates and overlays. Please see the attached User Guide which outlines the process. Our goal is to ensure that registrations are accurate as well as ensuring all regulatory guidelines are followed.

Here are some tips to follow:

- The patient's name must always match the legal ID. This means if the patient has a middle name on their ID, it must be entered in the **Middle name** field in Epic.
    - The legal ID may not clearly list "Middle Name" as a field so it's important to validate with the patient if the name listed on the ID is a middle name. In the example below, the registrar was able to validate with the patient that the **FN** field on the ID shows the patient's first name of **Ima** and the Middle name of **May**.

This is how this patient's name should be entered in Epic:
When creating a new patient, the middle name on the legal ID should be entered as follows:

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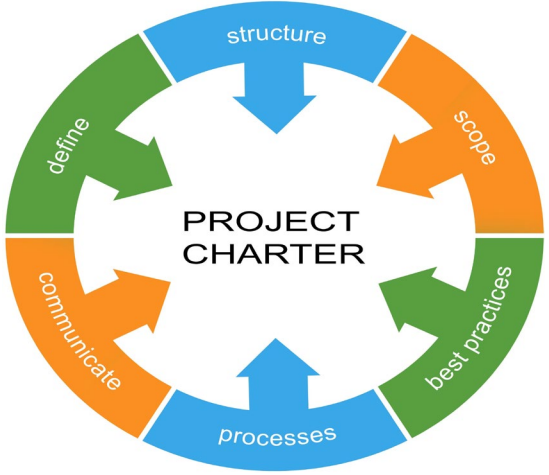
UCI Health Sample Charter



Denial Avoidance Charter

Mission:

Create a multidisciplinary team, with a data-driven strategic approach across our enterprise to prevent avoidable denials.

Background:

Denial management is an enterprise issue and requires commitment and collaboration throughout the enterprise.

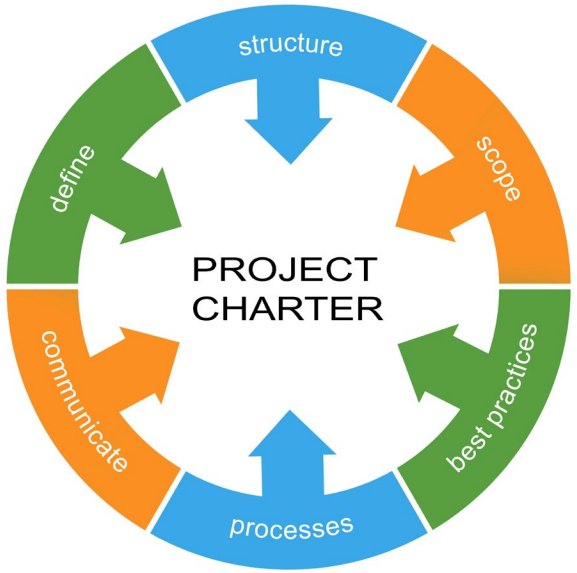
Denials and downgrades are on the rise at UCI Health, as payers implement increasingly stringent guidelines for payment of services rendered. The denials lead to rework, increased A/R Days and potentially lost revenue.

Objective:

Lower HB Primary Denial Rate to 9% from 11.5% by FYE 2024

Establish processes to ensure prevention of avoidable denials.

UCI Health Sample Charter (cont)



Purview:
- Monitor and report metrics
- Develop communication channels and procedures for needed IT changes
- Define workflows and Policies and Procedures (P&P) to avoid preventable denials; Define and hardwire P&P
- Establish accountability for departments

Function:
- Analyze denials data to identify key areas of high dollar or high-volume denials within specified areas
- Organize and facilitate small workgroup meetings to discuss specific areas of opportunity
- Hold overall check-in meetings to report updates and outcomes

Scope:

The below areas were identified as of high importance during the creation of this document. Additional areas of focus may be added in the future.

Drug/Infusion Center Authorization Denials (High Dollar)

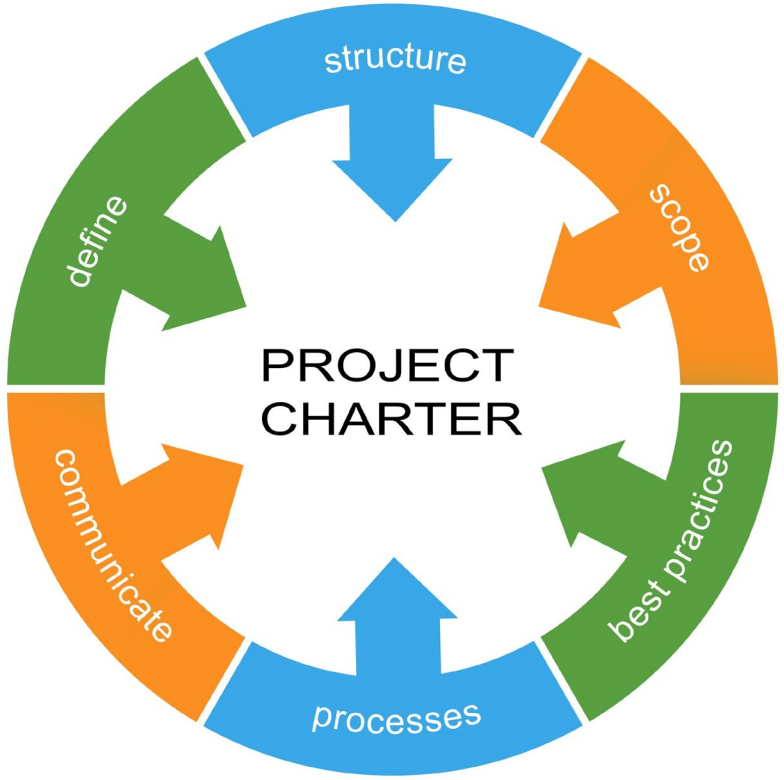
Ambulatory Authorization Denials (High Dollar)

Physician Order matching Level of Care (High Dollar)

Billing Governmental Edits leading to denials

Eligibility/Registration Denials

UCI Health Sample Charter (cont)



Risks:

- Operations/Physician involvement and buy in
- Resource time and scheduling
  - Access and availability of operational partners
  - Competing priorities

Format:

Large Group Meeting

- Discuss initiatives and provide updates
- Review metrics for area of focus

Small Group Meeting

- Deep dive into metrics and examples
- Discuss potential process and configuration changes
- Finalize update, escalations to reporting to large group

Attendees:

Role	Description
Project Manager	- Schedule and facilitate meetings. Run through agenda and follow up with notes and reports - Coordinate PowerPoint slides with metrics and current objectives prior to meeting
Revenue Cycle Leadership	- Ensure revenue cycle accountability and success of program
Ambulatory Leadership	- Ensure Ambulatory team accountability and success of program
Focus Area Representatives	- Report on area metrics and current objectives
Reporting Analyst	- Facilitate and support report generation and data access
Note Taker	- Take and distribute meeting notes

Tracking/Trending Technical Dashboards

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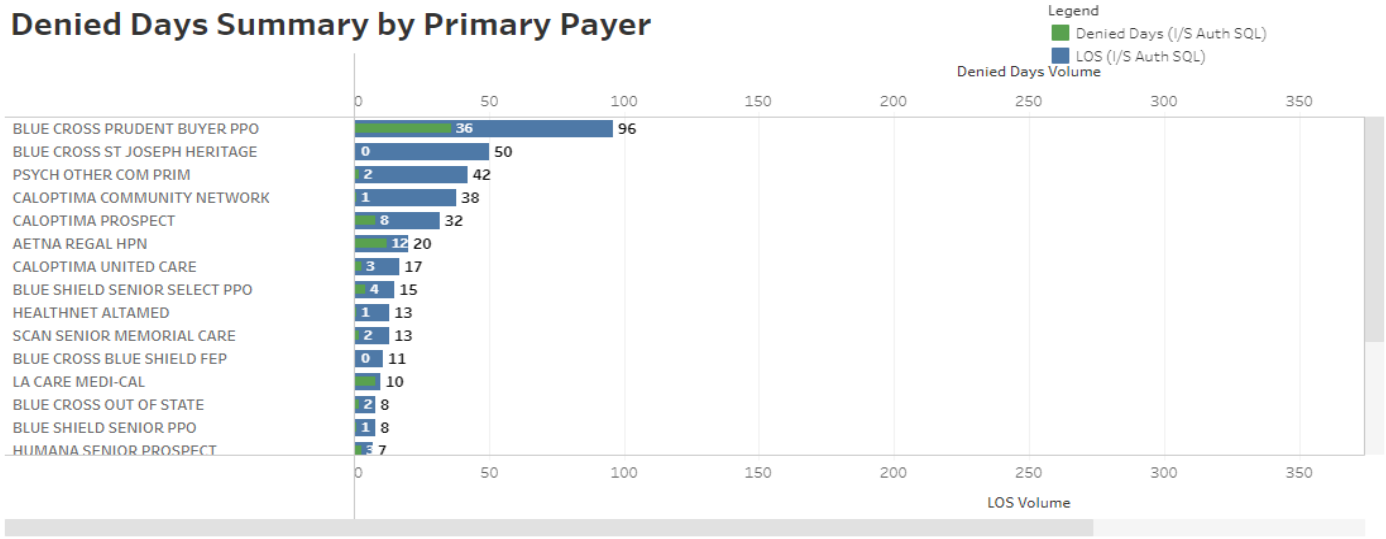
Initial/Subsequent Authorization Summary

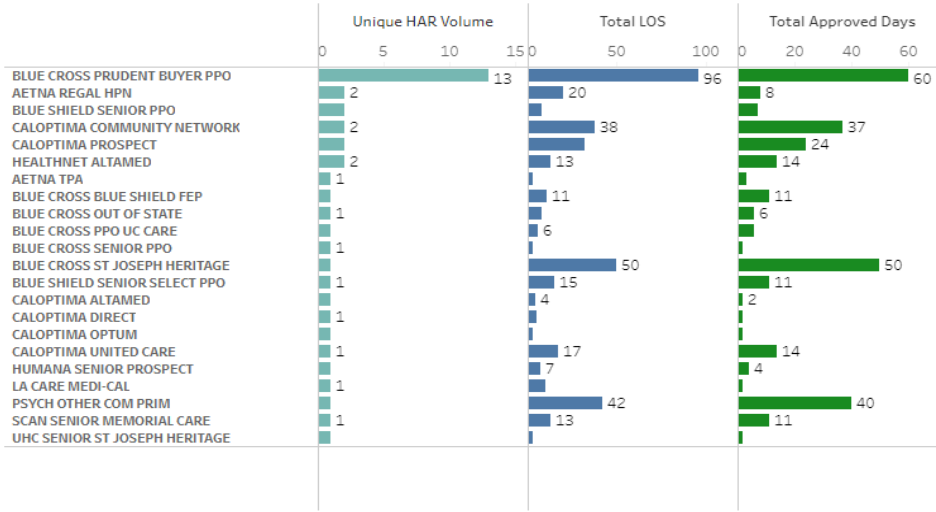
Data up to: 2024-08-31

Admission Month: Last 3 Months

Denied Days Summary by Primary Payer



Approved Days Summary by Payer



Denied Days By Primary Payer By Admit Month

	2024		
	June	July	August
AETNA REGAL HPN	0	12	
AETNA TPA			0
BLUE CROSS BLUE SHIELD FEP			0
BLUE CROSS OUT OF STATE			2
BLUE CROSS PPO UC CARE	0		

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Tracking/Trending Avoidable Days Dashboards

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Admission Month

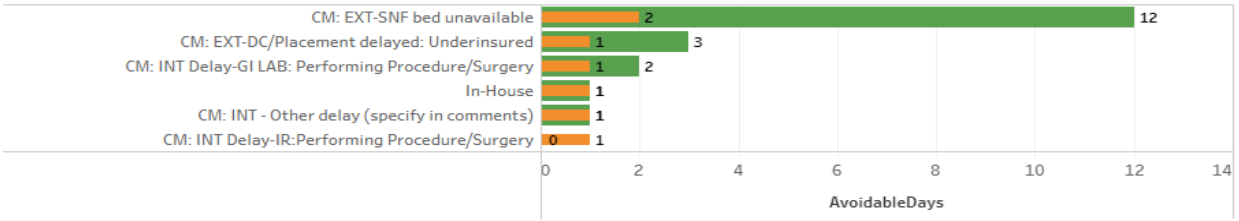
Last 3 Months

Avoidable Days Summary

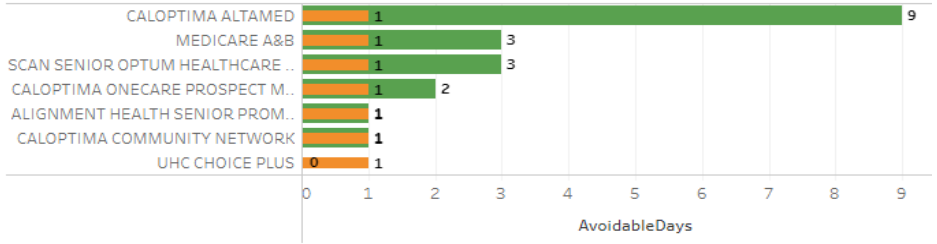
Data up to: 2024-08-31

Measure Names
AvoidableDays
HAR Count

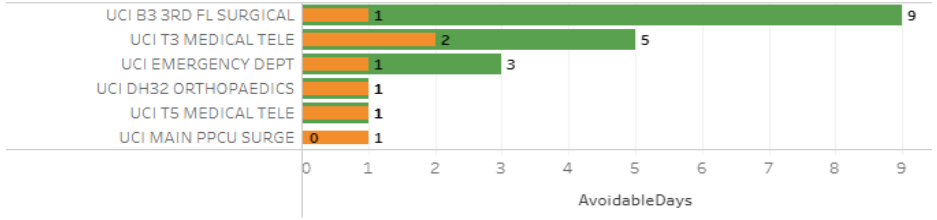
Volume Summary by Reason Code



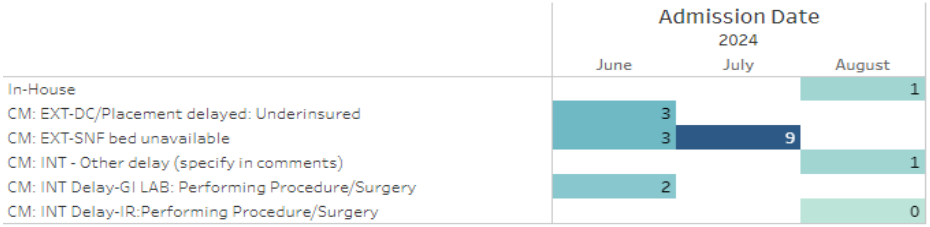
By Primary Payer



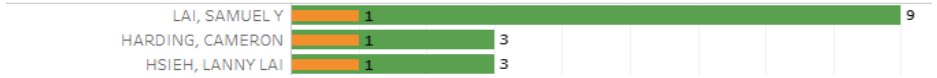
By Discharge Department



Monthly Volume by Reason Code



By Attending Provider



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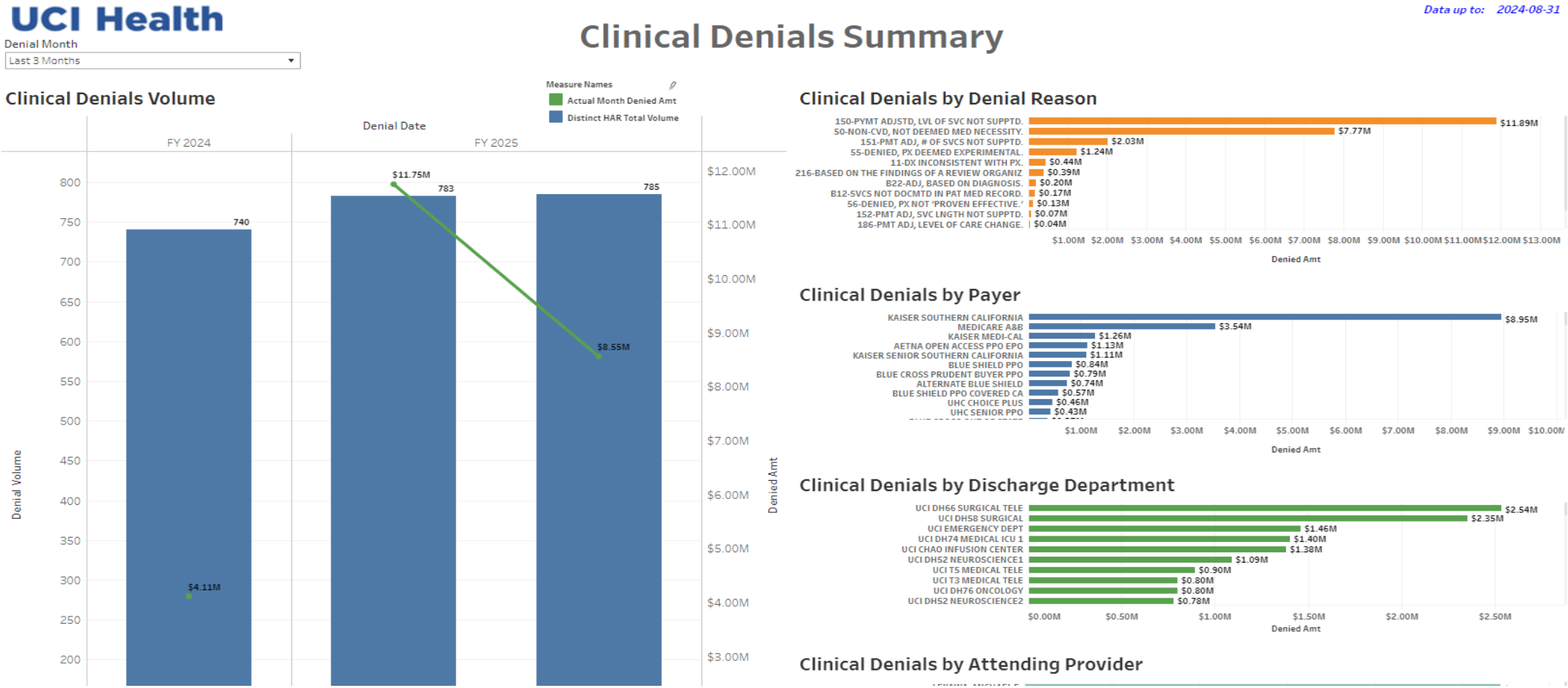
Tracking/Trending Clinical Dashboards



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Summary

- Payer frontend denials are persistent. It is more cost-effective to meticulously address details during the initial processing rather than reworking/appealing accounts later
- Tracking, Trending and Reporting must be conducted with intentionality
- Regularly scheduled denial management meetings are critical for reviewing progress and identifying opportunities for improvement
- If providers lose focus on denials, payers are likely to do the same thing
- Providing feedback to clinicians, case management/utilization management, and leadership is essential for driving change

QUESTIONS?

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