

The image features a white background on the left side with the FORVIS logo and title text. On the right side, there is a dark blue background with a network of glowing blue lines and nodes, resembling a data or fiber optic network. A thick red diagonal line separates the white background from the blue background.

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An Ounce of Prevention: Denials Management for Hospitals

February 15, 2023

TO RECEIVE CPE CREDIT

- You must respond to at least 3 of the 4 polling questions per CPE hour
- You must be logged in for a minimum of 50 minutes per every CPE hour in order to receive CPE credit

Learning Objectives

By the end of this session, you will be able to

Explain the impact denials have on performance

Understand how to measure & monitor denials performance

Discuss how to use denials analytics to drive performance improvement

Understand how payors pay & process or deny claims

Agenda

5 minutes

● Introductions

25 minutes

● Insurance Denials Impact on Healthcare Organizations

25 minutes

● Implementing a Denials Prevention Strategy

- *Assessing Denial Reduction Opportunity*
 - *Implementing a Denials Prevention Program Structure*
 - *Using Denials Data to Drive Improvement*
 - *Monitoring & Measuring Denials Performance*
-

5 minutes

● Questions

Meet the Presenters



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Insurance Denials Impact on Healthcare Providers

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Insurance Denials' Great Impact on Providers

Insurance Denials Have a Large Impact on Organizations' Financials & Patient Experience

Financial Impact

- **3.3%** hospitals' net revenue lost due to claim denials*
- **\$4.9M** average hospital annual net revenue lost due to denials**
- **12%** of total hospital claim charges submitted received an initial denial***

Cost of Re-Work

- **\$118** average to formally appeal a denied claim*
- **Re-work Costs** including staff & vendor labor (10 to 25% of payments in some cases)
- **Reduced speed to payment & AR resolution**

Patient Experience

- Unexpected **patient liabilities**
- **Delay in patient care** or statements received
- Required patient involvement in **complex appeals process**

- *Healthcare Business Insight (HBI) Hospital Financial Benchmarks Q1 2022 National Average**
- *Change Healthcare Study 2022***
- *Change Healthcare Study 2016****

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Insurance Denials Are Not Slowing Down

Year over Year Insurance Denials & U.S. Healthcare Complexity Continue to Rise

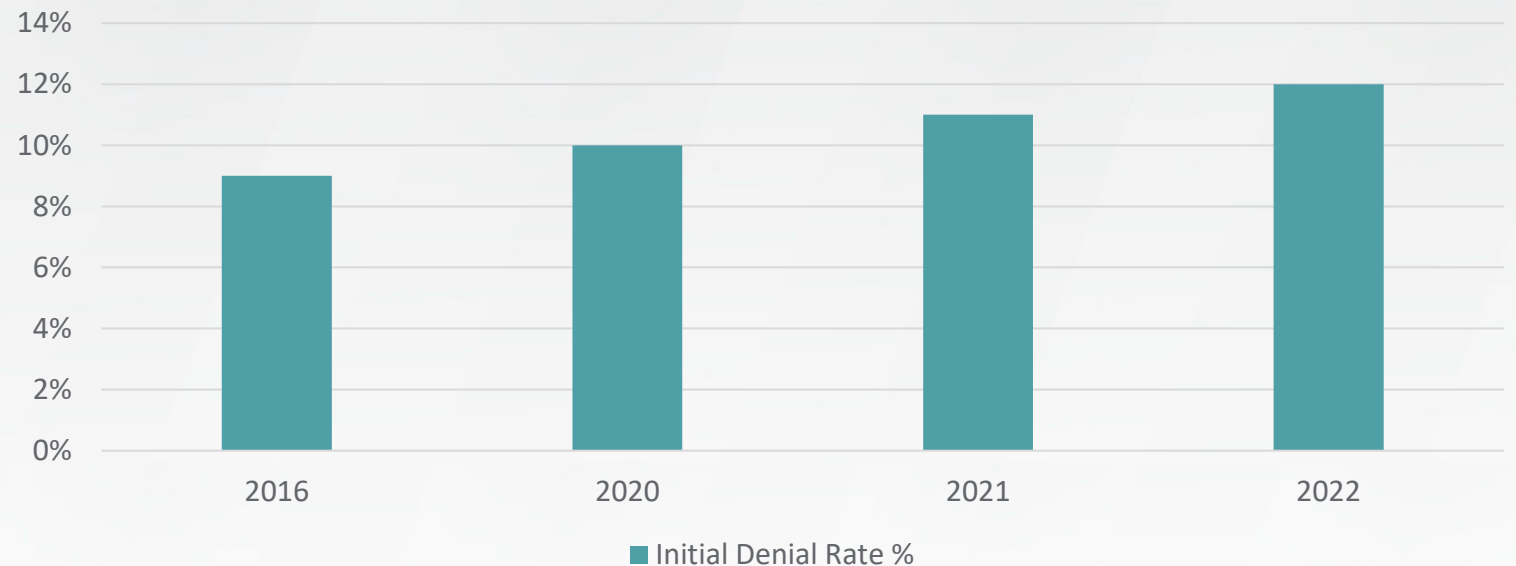
3% Increase in National Average Insurance Denial Rate from 2016 to 2022¹

100,000 Estimated number of payor policy changes between 2020-2022²

12% of all provider claims submitted are partially or completely denied¹

National Average Claim Denial Rate Trends

2016-2022¹



¹2022 revenue cycle denials index Change Healthcare

²Experian Healthcare Survey June 2022

Denial Reduction Is a Top Priority for Providers

Recent survey identified denial reduction as a top priority for healthcare professionals & key challenges to address

According to a Recent 2022 Survey¹ of healthcare professionals

- **75%** of survey responses indicated reducing denials is their highest priority & 70% said it is more important than prior to the pandemic
- **Top three reasons** healthcare professionals believe claims denials are on the rise
 - Insufficient data analytics (62%)
 - Lack of automation in the claims/denials process (61%)
 - Lack of thorough training (46%)

¹Experian Health - The State of Claims 2022

Provider Challenges Addressing Denials

Our clients & healthcare providers at large continue to struggle to reduce insurance denials & revenue loss from preventable operational issues

1

Revenue Cycle Staffing – Staffing & turnover challenges in revenue cycle have limited an organization's ability to proactively approach prevention initiatives & staff education

2

Denial Visibility & Reporting – Complex system & reporting limitations have limited providers' ability to prevent denials & monitor appeal success

3

Regulatory & Payor Complexity – Providers continue to have difficulties adhering to constantly evolving regulatory requirements & successfully defending post-payment audits

Experian Health - The State of Claims 2022

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Assessing Denials Reduction Opportunity

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Start with Assessing Denial Write-Off Reduction Opportunity

One of the first steps in reducing denials is understanding where & how much revenue you are losing & the financial opportunity for reduction.

Annual Denial Write-Offs by Adjustment Category	Gross Denial Write-Off Total
Authorization	\$23,344,000
Medical Necessity	\$17,508,000
Timely Filing	\$11,672,000
Credentialing	\$2,334,400
Late Charges	\$1,167,200
Total Gross Annual Denial Write-Offs	\$58,360,000
Estimated Blended Net Collection Rate	25.8%
Estimated Net Annual Denial Write-Offs	\$15,056,880
Annual Denial Write-Off Reduction Opportunity	
10% Reduction Net Annual Denial Write-Offs	\$1,505,688
20% Reduction Net Annual Denial Write-Offs	\$3,011,376
30% Reduction Net Annual Denial Write-Offs	\$4,517,064



Assess Opportunity to Reduce Re-Work Costs in Addition to Revenue Loss

Organizations have significant re-work costs in addition to net revenue loss due to insurance denials that are difficult to quantify

Denial Re-Work Cost Reduction Opportunity	Total
Estimated Annual Accounts Requiring Staff Resolution Effort (Accounts Worked) ¹	162,847
Current Average Minutes to Work an Account ²	11.0
Estimated Average Hourly Staff Rate ³	\$28
Opportunity Estimation	
30% Reduction in Denied Account Resolution Time (11 minutes to 7.7 minutes)	\$250,000
40% Reduction in Denied Account Resolution Time (11 minutes to 7.2 minutes)	\$365,000

¹ Example Hospital Insurance Accounts Multiplied by Claim Denial Rate & 2x additional re-work factor

² Example Avg. Minutes to work (HBI low range of accounts worked per hour)

³ Example Estimated blended Avg Hourly Labor Rate (AR team, Specialized Clinic Staff)

Implementing a Denials Prevention Structure

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A Strong Foundation Leads to Sustainable Success

Important for the entire organization to establish a vision for success that starts with identifying what success looks like through a committee charter that incorporates key elements

- Clear Committee Structure Roles & Responsibilities
- Consistent Meeting Structure, Agenda, & Cadence
- Denials Prevention Key Leader
- Success Metrics

Identify Denials Prevention Leaders

Important to identify diverse group of stakeholders as denials reduction improvement spans across the organization.

Hospital Stakeholder Sample Structure					
Executive Sponsors	<ul style="list-style-type: none"> ▪ CFO ▪ Clinical Executive 				
Committee Lead	<ul style="list-style-type: none"> ▪ Specialized Role—skillset with a strong understanding of overall operational process flow & ability to provide unbiased leadership. Initiative ownership may fit under the revenue integrity department 				
	Patient Access	Coding/HIM	PFS	Inpatient/UR	Clinic
Project Owner	<ul style="list-style-type: none"> ▪ Director – Patient Access 	<ul style="list-style-type: none"> ▪ Director – Coding/HIM 	<ul style="list-style-type: none"> ▪ Director – Business Office 	<ul style="list-style-type: none"> ▪ Director – Case Management/UR 	<ul style="list-style-type: none"> ▪ Clinic Operations Exec Leader
Project Support	<ul style="list-style-type: none"> ▪ Supervisor – Patient Access 	<ul style="list-style-type: none"> ▪ Supervisor – Coding/HIM 	<ul style="list-style-type: none"> ▪ Supervisor – Business Office 	<ul style="list-style-type: none"> ▪ Supervisor – Case Management/UR 	<ul style="list-style-type: none"> ▪ Team Lead – Clinic Operations
IT Support	<ul style="list-style-type: none"> ▪ IT Director ▪ Lead Analyst 				

Establish Leader Roles & Responsibilities

Important for the entire organization to establish a vision that starts with identifying what success looks like through a charter

Role	Key Responsibilities
Exec Sponsors	<ul style="list-style-type: none">▪ Oversight to the denial prevention initiatives▪ Approve initial & ongoing strategic objectives & goals▪ Support escalation of high-risk items & requests
Denial Prevention Leader	<ul style="list-style-type: none">▪ Responsible for overall initiative project management▪ Prepare, coordinate, & lead monthly denials steering committee meetings▪ Update team & monitor project progress against timelines & benefits▪ Lead initial & ongoing data analysis efforts & guide strategic direction
Project Support	<ul style="list-style-type: none">▪ Perform or oversee root cause denial sampling▪ Attend committee meetings & provide input on project initiatives▪ Organize sub-committee meetings▪ Support implementation of agreed-upon initiatives
IT/Reporting	<ul style="list-style-type: none">▪ Lead & champion improvement efforts involving IT or system updates or revisions▪ Generate ad-hoc reporting as needed



Implement a Consistent Structure

Consistency is key for reducing denials & improving revenue cycle performance

Monthly Denial Steering Meeting Cadence						
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

- Denial Data Analysis, Root Cause Issue Identification, Improvement
- Denial Subcommittee Meeting Dates
- Denial Leadership Committee Dates



Using Denials Data to Drive Performance Improvement

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Convert Denial Data into Meaningful Information

Convert Electronic Claim Response files (835s) & patient accounting system adjustment detail to useful information by cleansing, categorizing, & turning into actionable reporting

- Remit Reason codes into useful categories & preventable vs. unavoidable denials
- Additional useful categories including CPT code grouping, specialty, financial class, etc.

Electronic 835 file

```
SVC*HC>90792*324.98*132.47**1~  
DTM*472*20220906~  
CAS*CO*45*159.12**253*2.7**144*-2.48~  
CAS*PR*2*33.17~
```

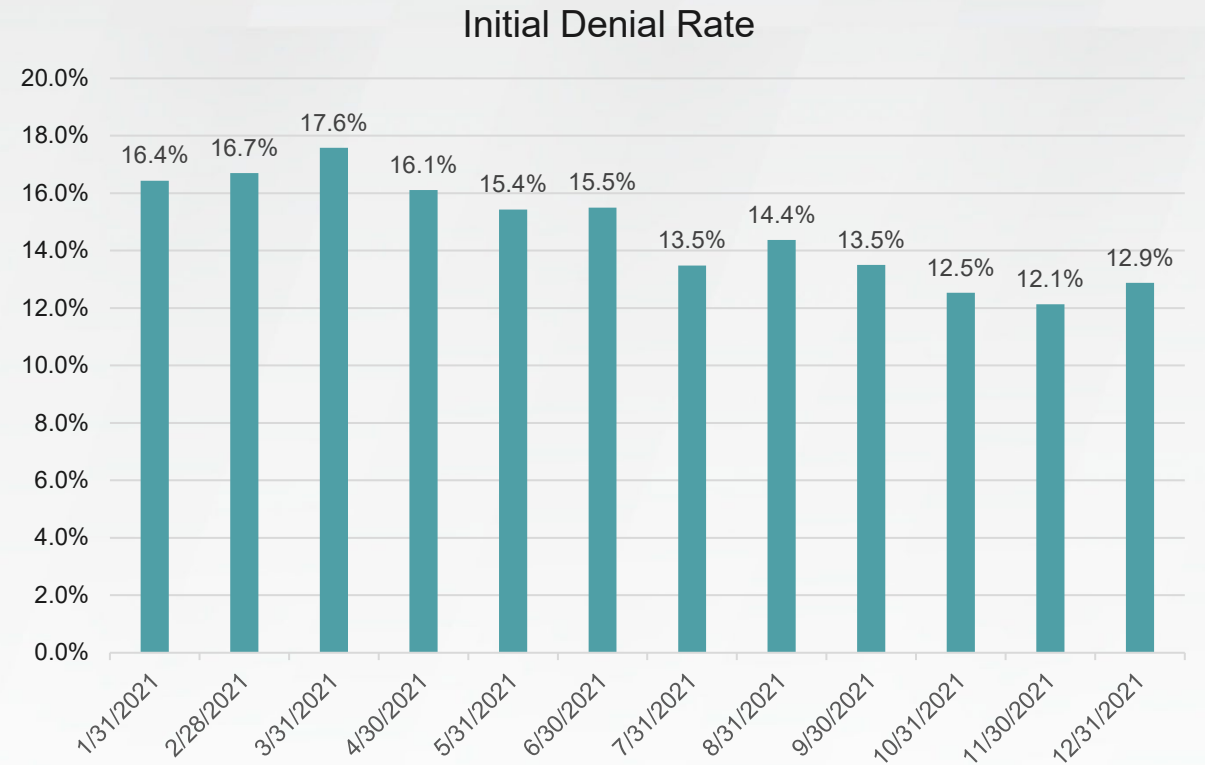
Patient Accounting System Write-Off Detail

Account Num	Name	Svc Date	Procedure	Description	Write-Off Amount	Performing Provider
HV0021233095	FORVIS, John	12/6/2022	DMCRABTIMELY	Denial MCRA&B Timely	\$37,933	John Smith
HV0021355463	Johnson, Bob	12/1/2022	DHUMMCRNOAUT	Denial Hum MCR No Auth	\$28,381	Jane Doe

Assess Historical Claim Denials for Trends

Perform an analysis of recent historical claim denial data to identify larger trends & themes across the organization & potentially “fatal” denial reasons & issues

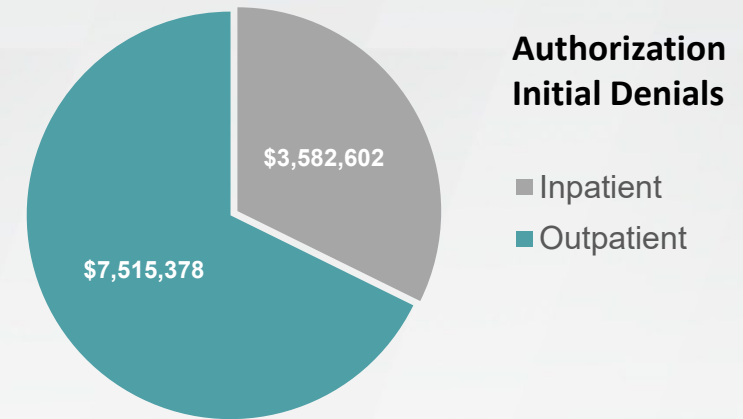
Claim Denial Reason Category	Gross Denied (\$)	Gross Denied (%)
Authorization	\$61,400,262	24.7%
Medical Necessity	\$61,311,080	24.7%
Past Timely Filing	\$44,548,687	17.9%
Coordination of Benefits	\$19,029,681	7.7%
Eligibility/Registration	\$16,684,327	6.7%
Credentialing	\$15,159,975	6.1%
Coding	\$14,453,152	5.8%
Additional Documentation Needed	\$10,098,045	4.1%
Other	\$2,755,734	1.1%
Max Benefit Reached	\$1,666,693	0.7%
Billing Error	\$765,897	0.3%
Bundled	\$459,406	0.2%
Total Gross Claim Denials	\$248,332,938	100.0%



Perform Denial Data Mining

Perform a deep-dive analysis across denial reasons, patient type, procedure code, location type, reason category, & procedure category to target specific initiatives

Denial/Non-Payment Reason Category	Denied Amount (\$)	Denied Amount (#)
Additional Documentation Needed	\$32,364,291	39,644
Authorization	\$11,097,981	10,504
Eligibility/Registration	\$8,922,371	14,132
Coordination of Benefits	\$7,633,978	13,444
Miscellaneous	\$4,917,687	8,420
All Others	\$19,387,811	36,860
Total	\$84,324,119	123,004



Outpatient Authorizations

Denial Reason Category	Denied Amount (\$)	Denied Amount (#)
Medication/Infusion	\$3,015,951	1,164
Surgical & Other Procedures	\$1,334,998	840
Radiology	\$798,202	812
Other	\$741,199	2,152
Radiation Oncology	\$484,131	60
All Others	\$1,140,898	2,024
Total	\$7,515,378	7,052

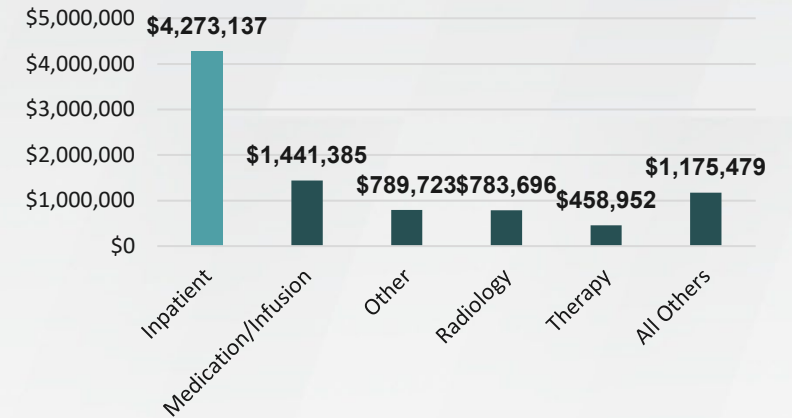
Top 3 Medication/Infusion CPT Codes	Denied Amount (\$)
HC-J9201 – Gemcitabine hcl injection	\$540,216
HC-J2505 – Injection, pegfilgrastim 6mg	436,174
HC-C9069 – Belantamab mafodotin-blmf	313,202
Total	\$1,289,592



Perform Denial Data Mining (con't)

Denial/Non-Payment Reason Category	Denied Amount (\$)	Denied Amount (#)
Additional Documentation Needed	\$32,364,291	39,644
Authorization	\$11,097,981	10,504
Eligibility/Registration	\$8,922,371	14,132
Coordination of Benefits	\$7,633,978	13,444
Miscellaneous	\$4,917,687	8,420
All Others	\$19,387,811	36,860
Total	\$84,324,119	123,004

Eligibility/Registration by Procedure Category



Eligibility/Registration – Inpatient Reason Categories


Denial Reason Category	Denied Amount (\$)	Denied Amount (#)
273 – Coverage/program guidelines were exceeded.	\$3,100,713	120
140 – Patient/Insured health identification number & name do not match.	\$544,202	216
177 – Patient has not met the required eligibility requirements.	\$212,291	112
26 – Expenses incurred prior to coverage.	\$127,294	240
272 – Coverage/program guidelines were not met.	\$80,672	220
All Others	\$207,965	968
Total	\$4,273,137	1,876

All \$3.1M driven by one payor


Identify & Sample Denied Claims

Use denials data analysis to identify a population of accounts to uncover key root cause issues contributing to unpaid claims

▼ < Scorecard Denial Rate - Trending Denials - Trending Denials - Details Denials - Export Write Off - Trending Write Off - Export Reconciliation & Unmapped C... User G

  **CLAIM DENIALS EXPORT DATA** 

Source: FORVIS Denial Solution Dashboard Demo

Filter Patient Name or ID # Service Date Range 11/24/2017  — 1/2/2023  7/3/2022  — 1/10/2023  Denied Amount \$0.10 

	Patient Name	Patient Claim #	Patient ID #	Location Type	Location	Patient T..	Provider	Claim Status	Group Code	Adjustment Reason Category	Rea
	Last, First64398480000..	64398480000AAB		Clinic	Rural Health Clinic ..	OP Clinic	MCNICHOLAS HEN..	Processed as Pri..	Patient Responsibility	Eligibility/Registration	26 -
2	Last, First69434480000..	69434480000AAB	MRN# MR00..	Hospital	Demo Hospital	OP	THOMAS, GEORGE	Processed as Pri..	Contractual Obligations	Eligibility/Registration	204

▪ Source: FORVIS Denial Solution Dashboard Demo

Structured Denial Root Cause Issue Identification

Use a structured approach & templates for denial review to identify & quantify issues impacting performance

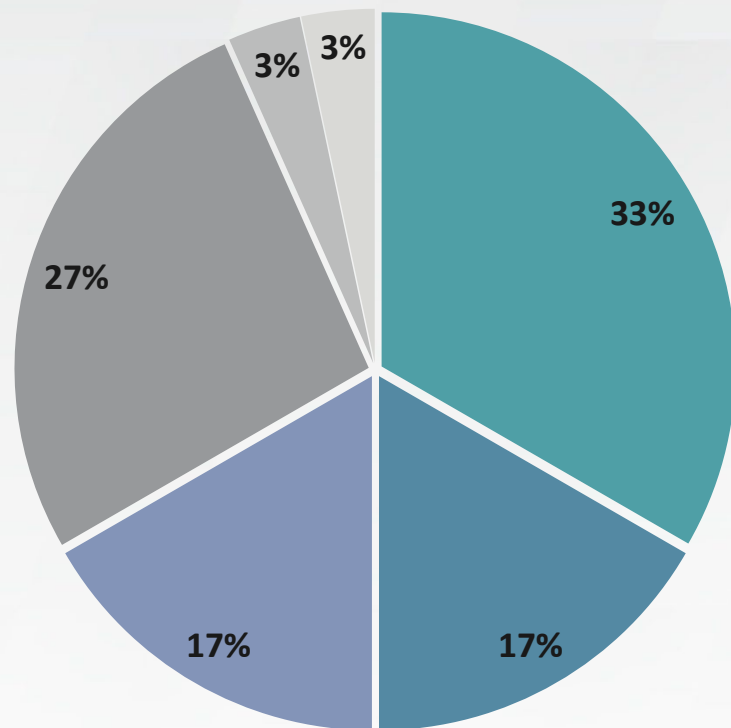
Account	Payor	IP Decision Criteria	Notification Submitted Timely	Clinicals Submitted Timely	Initial Review Complete	Concurrent Review Complete	Medical Necessity Met	DRG2	Additional Comments
4002270678-1	MERIDIAN HEALTH PLAN	MCG	Yes	Yes	Yes	Yes	Yes		This patient should be OBV from beginning.
4002262555-1	AETNA	MCG	Yes	Yes	Yes	Yes	Yes	812	Missing Physician Operative Report
4002250443-2	MOLINA	MCG	Yes	Yes	Yes	Yes	Yes	917	denied inpatient initially, p2p sch for 1/14 which overturned the MD decision to deny. Ref#2201191151
4002255841-1	AETNA	MCG	Yes	Yes	Yes	Yes	Yes	291	Denied inpatient, sent to UMPA, agreed to OBV, remit to OBV.
4002190886-7	IOWA TOTAL CARE	MCG	No	No	Yes	Yes	Yes	854	no auth tab created

▪ Source: FORVIS Denial Solution Dashboard Demo

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Root Cause Analysis & Issue Tracking

Consolidate & discuss root cause issue findings through meetings to steer performance improvement initiatives



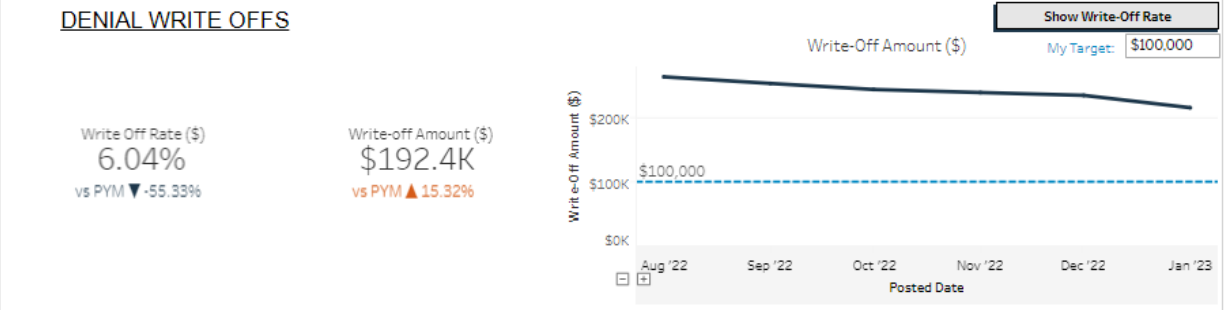
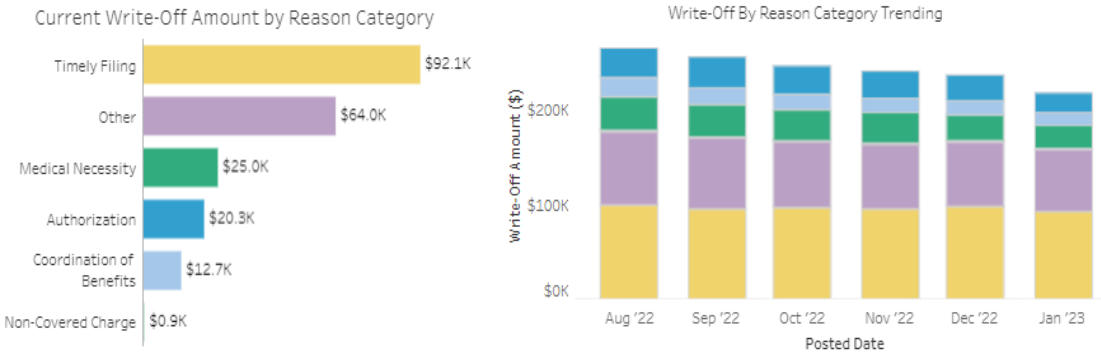
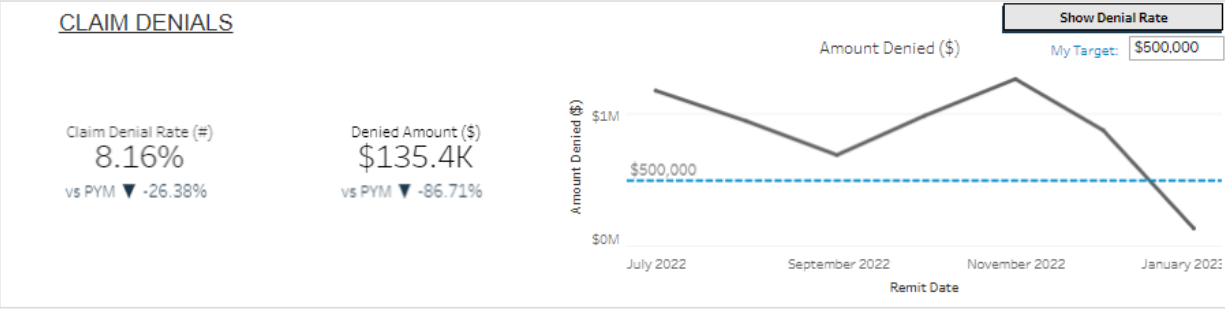
Outpatient Authorization Denied Claims by Root Cause (20 Claim Sample)

- Incorrect Insurance – No Auth Required for registered insurance
- Retro Medicaid Found – No Retro Auth Obtained
- Tech Revised Imaging Test Ordered – Wrong CPT authorized
- Late Schedule Add-on – Auth not obtained
- Auth Initiated – Denied for Medical Necessity

■ Source: FORVIS Denial Solution Dashboard Demo

Denials Scorecard & Dashboard

Implement an executive level to monitor improvements for visibility into baselines, targets, & industry benchmarks



*Source: FORVIS Denial Monitoring Tool



Monitoring & Measuring Denials Performance

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Using Denial Metrics to Trend Performance

Understand key performance metrics to measure organizational denials reduction performance

Metric	Value	Calculation	Primary Data Source
Clean Claim Rate %	Trending indicator of successful claim submissions to the payor	Number of claims submitted that passed edits requiring no manual intervention / number of claims submitted	Claims Submitted Detail – Claim Scrubber
*Remittance Denial Rate % (#)	Trending indicator of % of claims denied by payor	Total number of claims denied / Total number of claims remitted	835 Files
Net Denials Written Off as % of Net Revenue	Trending indicator of revenue lost from denials	Net Dollars written off as denials / Average monthly net patient service revenue	Patient Accounting System & Income Statement

*A claim should be determined “denied” based on the claim adjustment reason code (CARC) & group code mapping provided on the response back from the payor. HFMA recommends excluding non-covered denials, denials for patient responsibility, RAC recoupments, duplicate denials, & shadow claims in denial rate

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▪ Source: HFMA Calculations

Set Organizational Denials Targets & Goals

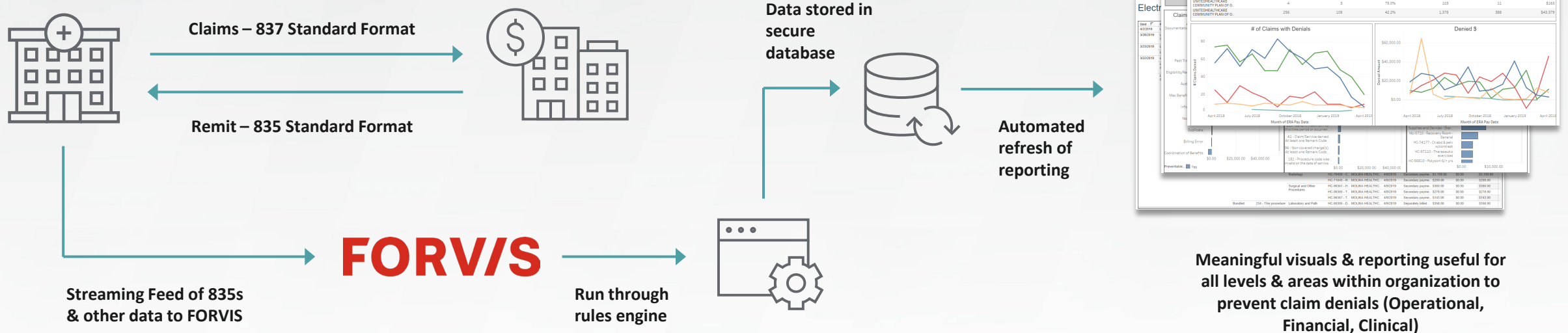
Establish initial baselines & targets for key performance indicators based on improvement towards industry benchmarks

KPI – Hospital	Top Quartile*	National Average*	Ryan Hospital (Baseline)	Improvement Opportunity		Target Reduction		
				Top Quartile	Nat. Avg.	Conservative	Moderate	Aggressive
Clean Claim Rate %	95.93%	94.14%	75%	20.93%	19.14%	10.00%	15.00%	20.00%
Remittance Claim Denial Rate % (#)	8.0%	12.0%	15.0%	-7.00%	-3.00%	1.00%	2.00%	3.00%
Denial Write-Offs as a % of Net Patient Revenue	1.75%	3.44%	4.00%	-2.25%	-.56%	.5%	1%	1.5%

**Source: Healthcare Business Insight (HBI) Hospital Financial Benchmarks Q1 2022 National Average*

FORVIS' Denials Management Monitoring Approach

- FORVIS receives an automated feed of the organizational electronic insurance claim response data (835s) & uses a rules engine to turn this information into timely meaningful insights to help support identification of root cause issues driving denials
- Rapid initial installation timeline (average 4 weeks)

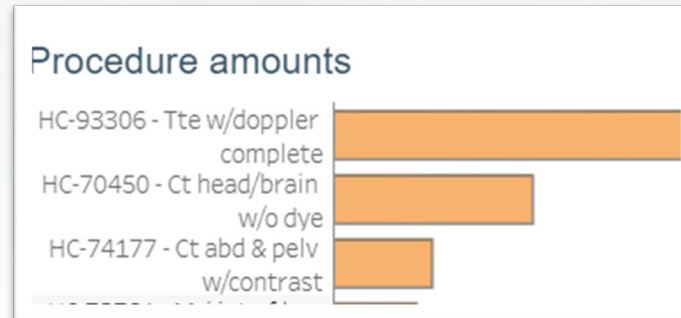
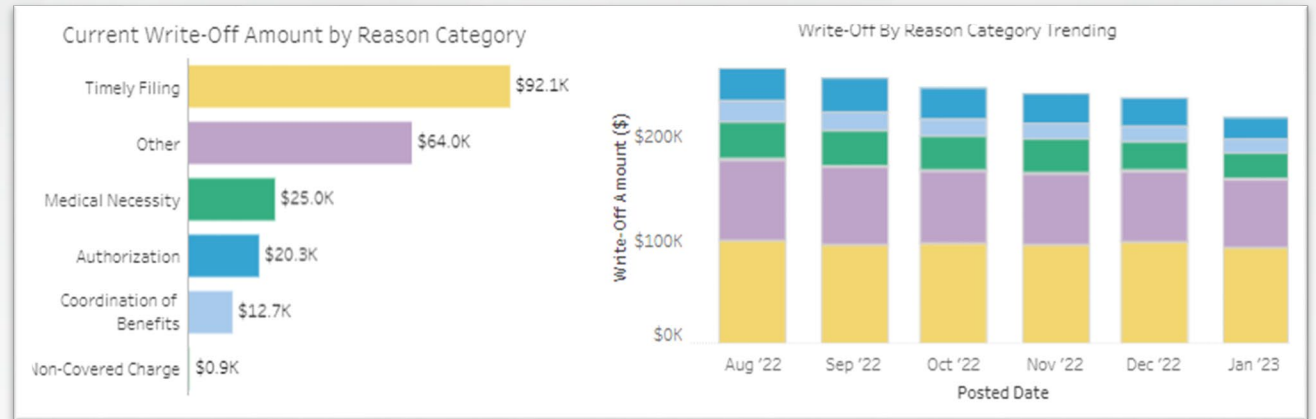


Source: FORVIS Denial Solution Dashboard Demo

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FORVIS' Denials Management Monitoring Approach

- Quick Install & Low Maintenance
- Consolidated denial reporting across locations & specialties
- Visibility into denials revenue impact, trends, & performance
- Detailed analysis & claim level drill-down capabilities
- Facilitates denial visibility & prevention strategy





Questions?

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