

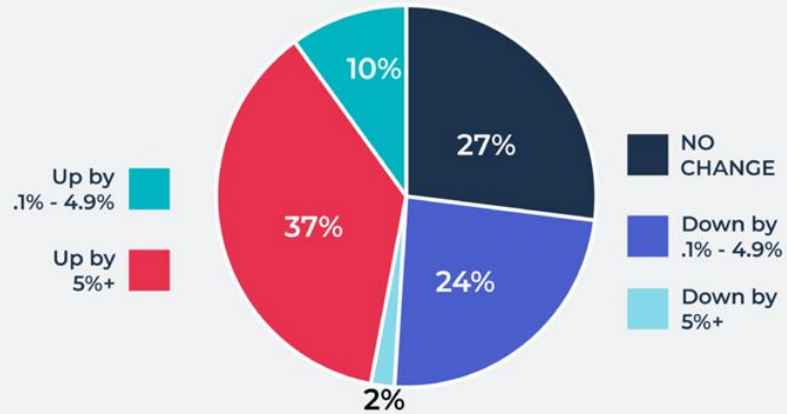


“A successful team is a group of many hands and one mind.” – Bill Bethel

Patient Access Denials Fact or Fiction

Presented by Amy Sherman

CFOs and revenue cycle leaders were asked, "How does your denials rate compare to this time last year?"



Errors in Patient Access Such as Eligibility or Missing Prior Authorization Cited as Top Reason for Initial Payer Denials by Financial Leaders

10 Common Mistakes That Cause Denials

- Claim is not specific enough.
 - Each diagnosis must be coded with the highest specificity. Lack of Documentation
- Claim is missing information. Any missing/incomplete Patient Information may be cause for a denial, but the most common missing items are:
 - Date of accident
 - Date of medical emergency
 - Date of onset
- Claim not filed on time (Timely Filing)
- Coding issues.
- Duplicate billing.
- Upcoding or unbundling.
- Further documentation requested to support medical necessity.
- Referral or prior authorization required.
- Services not covered/coverage terminated.

FY22 Patient Access Dashboard

Registrations by Type	FSH	GSH	HHC	UMH	BAL Region
Inpatient	19,268	85,100	8,295	9,757	122,420
ER Admit	10,539	6,702	4,566	6,363	28,170
SMS Outpatient	88,545	89,170	37,947	73,890	289,552
IDX Outpatient	60,231	38,887	14,180	10,025	123,323
ER Registration	45,590	29,341	28,232	35,329	138,492
Total	224,173	249,200	93,220	135,364	701,957

Registration Accuracy Rates***	FSH	GSH	HHC	UMH	BAL Region
SMS	1292	1751	464	1276	4,783
IDX	715	614	63	348	1,740
Total	2007	2365	527	1624	6523
Accuracy Rate	99.10%	99.05%	99.43%	98.80%	99.07%

Gross Charges	\$607,874,730	\$298,993,677	\$202,220,009	\$441,571,486	\$1,550,659,902
Technical Denials Count	3270	2958	1093	2508	9,829
Technical Denials Dollars	<u>\$4,010,139</u>	<u>\$1,700,925</u>	<u>\$960,171</u>	<u>\$2,627,487</u>	<u>\$9,298,722</u>
% of Denials	0.66%	0.57%	0.47%	0.60%	0.60%
Denial Count/Registration Count	1.46%	1.19%	1.17%	1.85%	1.40%

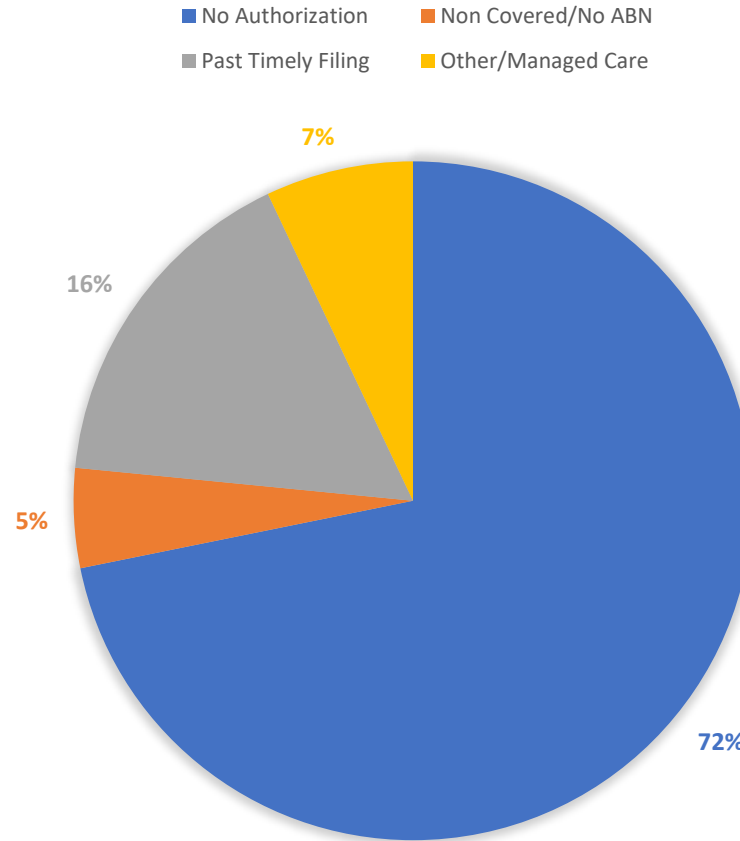
FY22 Baltimore Region Technical Denial Review

\$9,298,722 Dollars Denied

Reviewing the payor remit reason codes for denials presumptively shows the root cause;

- **No Authorization**
 - 5,826 encounters
 - \$6,677,592 dollars denied
- **Non-Covered/No ABN**
 - 2,796 encounters
 - \$440,940 dollars denied
- **Past Timely Filing**
 - 898 encounters
 - \$1,526,494 dollars denied
- **Other/Managed Care**
 - 521 encounters
 - \$653,696 dollars denied

FY22 BALTIMORE REGION TECHNICAL DENIAL
DOLLARS AS % OF REASON CODE



72% of the technical denials received are for No Authorization reason codes

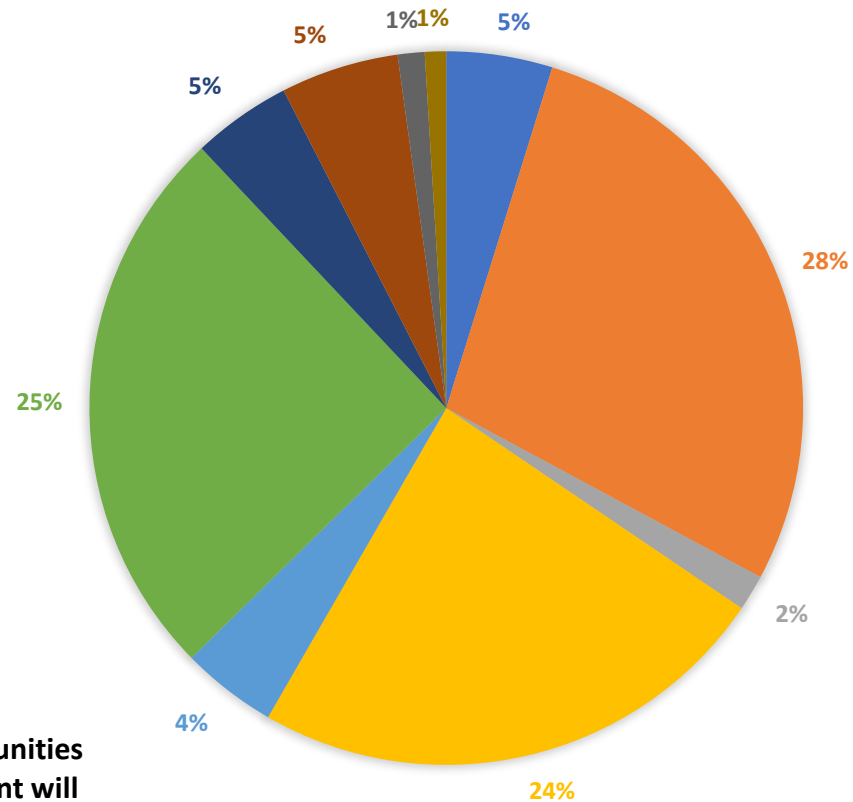
FY22 Baltimore Region Technical Denial Review

Baseline review of data to identify areas that could be attributed to the front-end scheduling, registration, and current workflow.

- **No Authorization**
 - **No Auth - Dept Responsible**
 - 1,048 encounters
 - \$1,525,487 dollars denied
 - **Denied CPT/Auth Mismatch**
 - 233 encounters
 - \$1,295,492 dollars denied
 - **No Auth - Late Ins Update**
 - 172 encounters
 - \$1,376,919 dollars denied
 - **Lab No Auth Denial**
 - 2,185 encounters
 - \$261,389 dollars denied
- **Non-Covered/No ABN**
 - **Non-Covered Services**
 - 690 encounters
 - \$230,492
 - **Nursing Home Lab Services**
 - 1,184 encounters
 - \$116,206 dollars denied
 - **National Drug Coverage Denial**
 - 919 encounters
 - \$88,443 dollars denied
- **Other/Managed Care**
 - **MA Technical Denial UR**
 - 33 encounters
 - \$244,506
 - **MA Denial Technical Patient Financial Services**
 - 1 encounter
 - \$291,044
 - **Disputed Claim Managed Care**
 - 219 encounters
 - \$66,172
 - **Capitated Services**
 - 246 encounters
 - \$52,420

FY22 BALTIMORE REGION TECHNICAL DENIAL BREAK DOWN

- Lab No Auth Denial
- No Auth - Dept Responsible
- National Drug Coverage Denial
- Denied CPT/Auth Mismatch
- Non-Covered Service
- No Auth - Late Ins Update
- MA Technical Denial UR
- MA Denial Technical Patient Financial Services
- Disputed Claim Managed Care
- Capitated Services



Several opportunities for improvement will require a phased approach on focus areas and dedicated resources

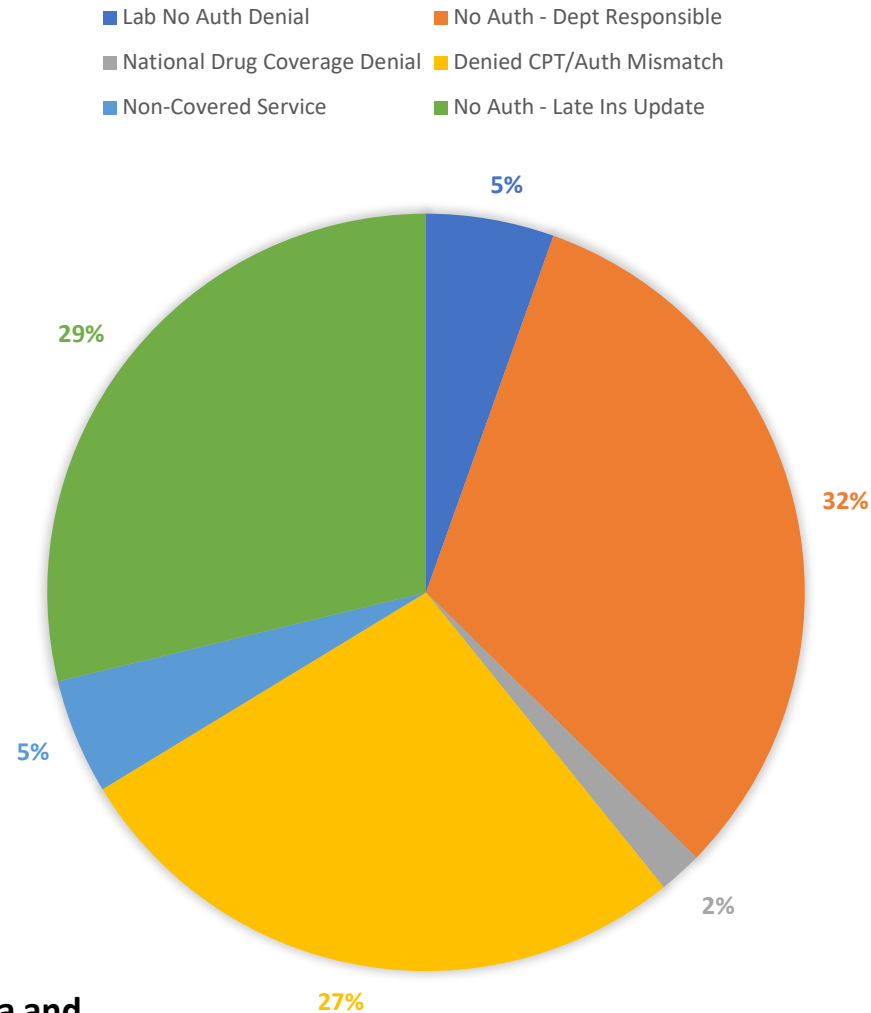
FY22 Baltimore Region Technical Denial Review

Phase Approach

Reviewing the payor remit reason codes for denials presumptively shows the root cause

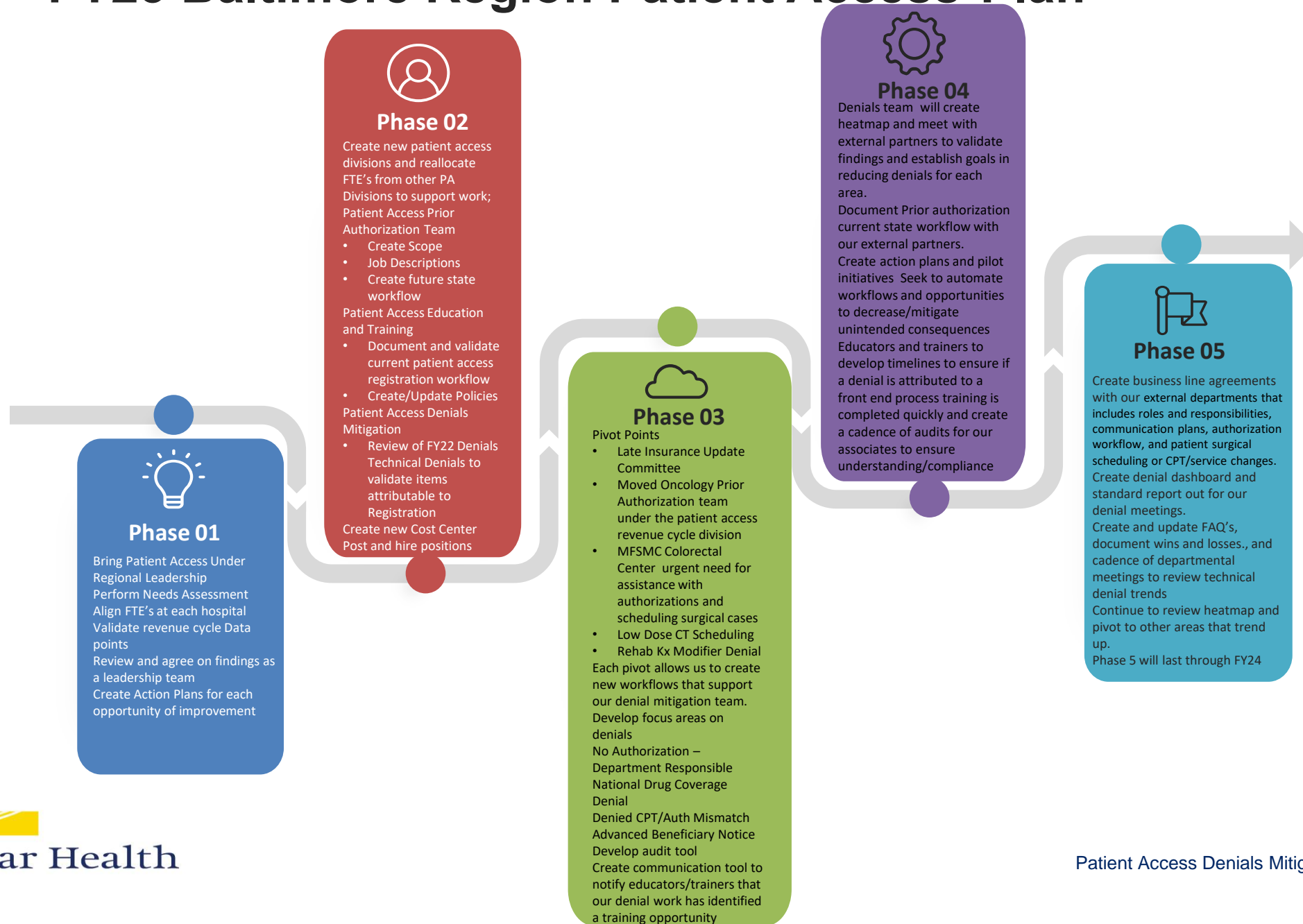
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FY22 BALTIMORE REGION TECHNICAL DENIAL DRILL DOWN



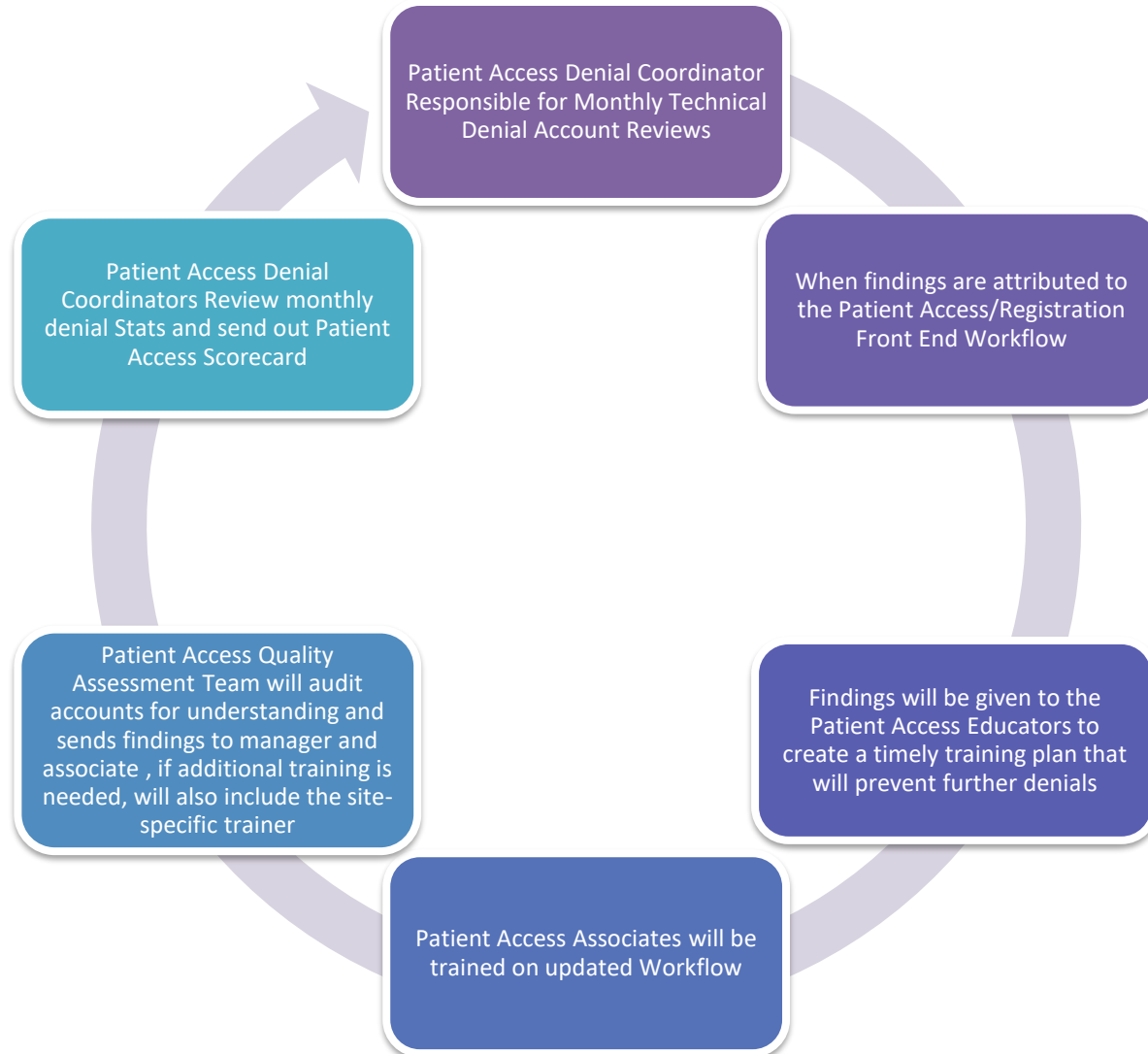
We reviewed the data and divided the focus in 2 buckets- 1. High Dollar and 2. High Volume

FY23 Baltimore Region Patient Access Plan



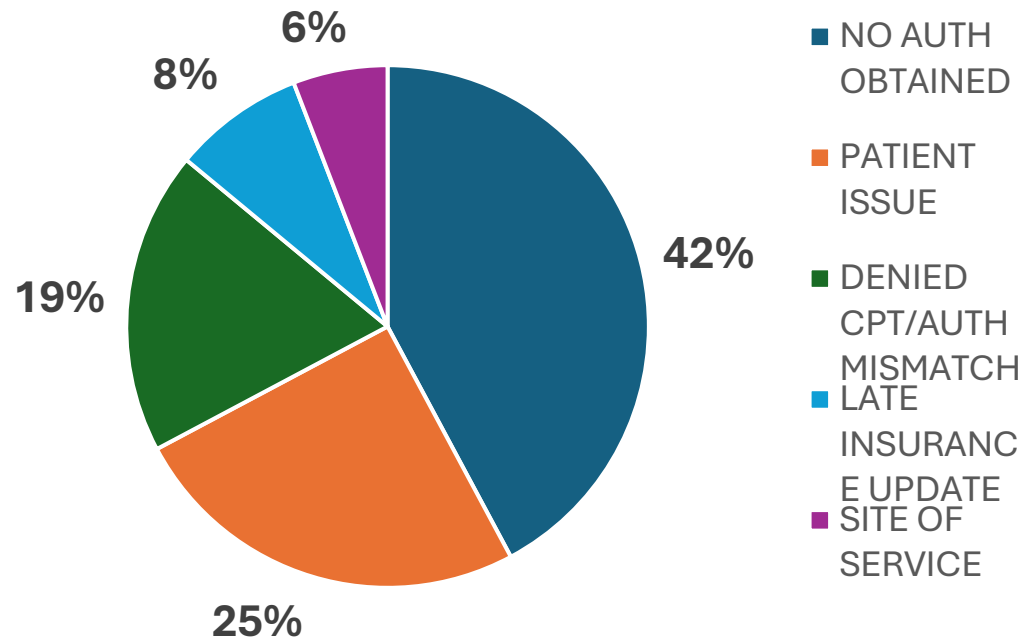
FY24 Patient Access Quality Assessment, Education, Training and Denials Mitigation Workflow

Sustaining Positive Trends and Quickly Identify New Ones

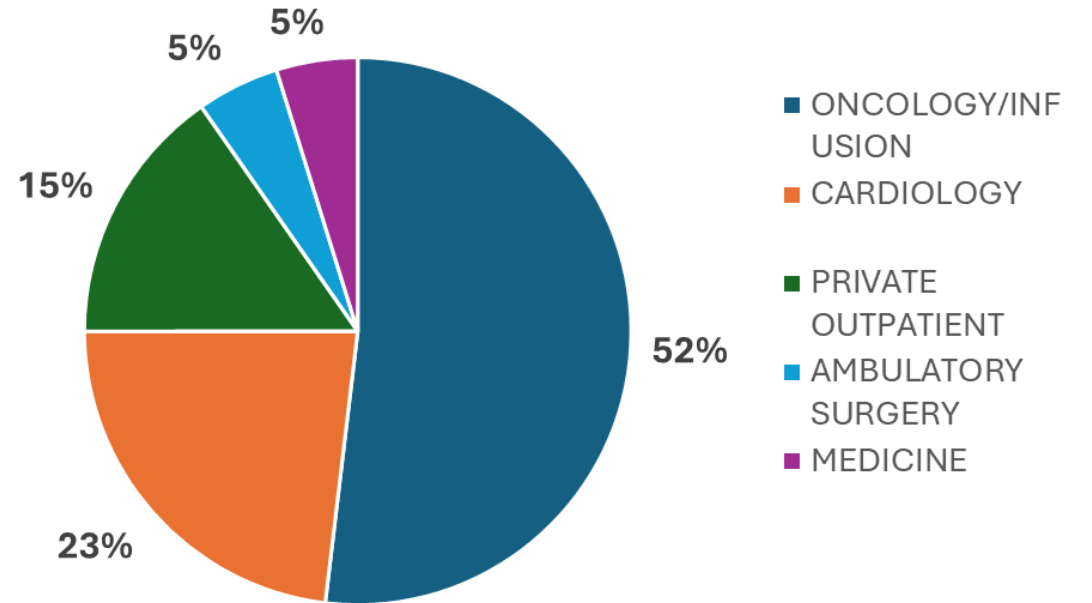


Identifying the Problem – Root Cause Analysis

Top 5 Root Cause Analysis - Technical Denial



No Authorization - Department Responsible





Case Study

- Patient being treated with Rituxan (Rituximab) since May 2019, with no adverse side effects.
- CVS Blue Cross approved services to be done since March 2021.
- Rheumatology attempted to obtain an updated authorization to replace an expired authorization.
- CVS Blue Cross denied the request stating that the patient hadn't failed the use of the preferred biosimilars.
- Recently, Rituxan (Rituximab) was listed as a non-preferred product.
- The office updated the authorization request to one of the preferred biosimilars.
- Unfortunately, the order was not updated to the new drug and the Rituxan (Rituximab) was provided.
- Resulting in a \$40,415.00 denial
- Denials Team reached out Blue Cross Rep asking for account review and reconsideration
- Blue Cross Rep was able to have denial overturned and sent for reprocessing
- Total Overturned: \$40,415.00

NEW TREATMENT DETAILS (drug name with dose/m2 and mode of administration): Nivolumab 480mg/Relatlimab 160mg IV every 28 days

Until Progression: Yes

Tx Plan-Regimen details: Regimen Name Regimen Description Intent of Therapy

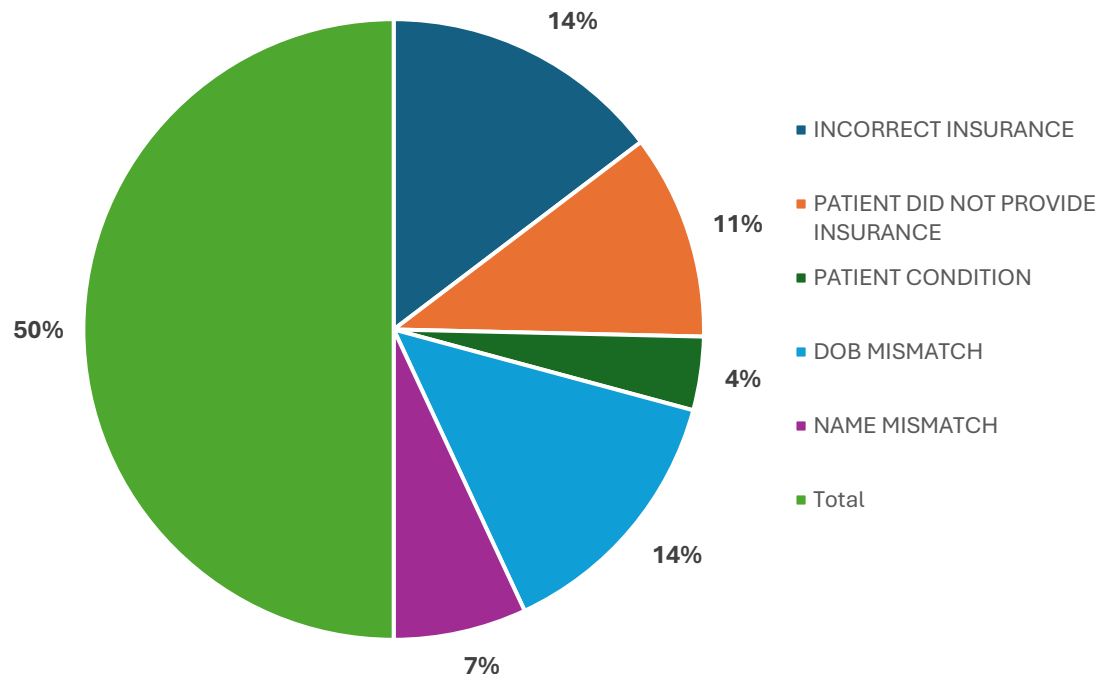
ONC Nivolumab/Relatlimab Q4wks Nivolumab 480mg/Relatlimab 160mg IV every 28 days given on day 1 until disease progression or unacceptable toxicity Reference: Tawbi et al. NEJM Jan 2022 Neo-adjuvant

Case Study 2

- Blue Cross denied 3 visits for J9298 Opdualag (Nivolumab & Relatlimab-rmbw) totaling \$220,799.35
- Physician ordered Nivolumab & Relatlimab-rmbw.
- This drug is a combination of J9299 Opdivo (Nivolumab) & Relatlimab-rmbw; however, there is a new J code; J9298 Opdualag (Nivolumab & Relatlimab-rmbw)
- The verifier saw the Nivolumab and requested an authorization for J9299 Opdivo (Nivolumab)
- This plan allows for retro-authorization within 6 months from the date of service.
- We were able to obtain a retro-authorization, re-bill and recover \$220,799.35
- Education was provided to the Oncology verifiers

Identifying the Problem – Root Cause Analysis

Deep Dive Root Cause - Patient Issue

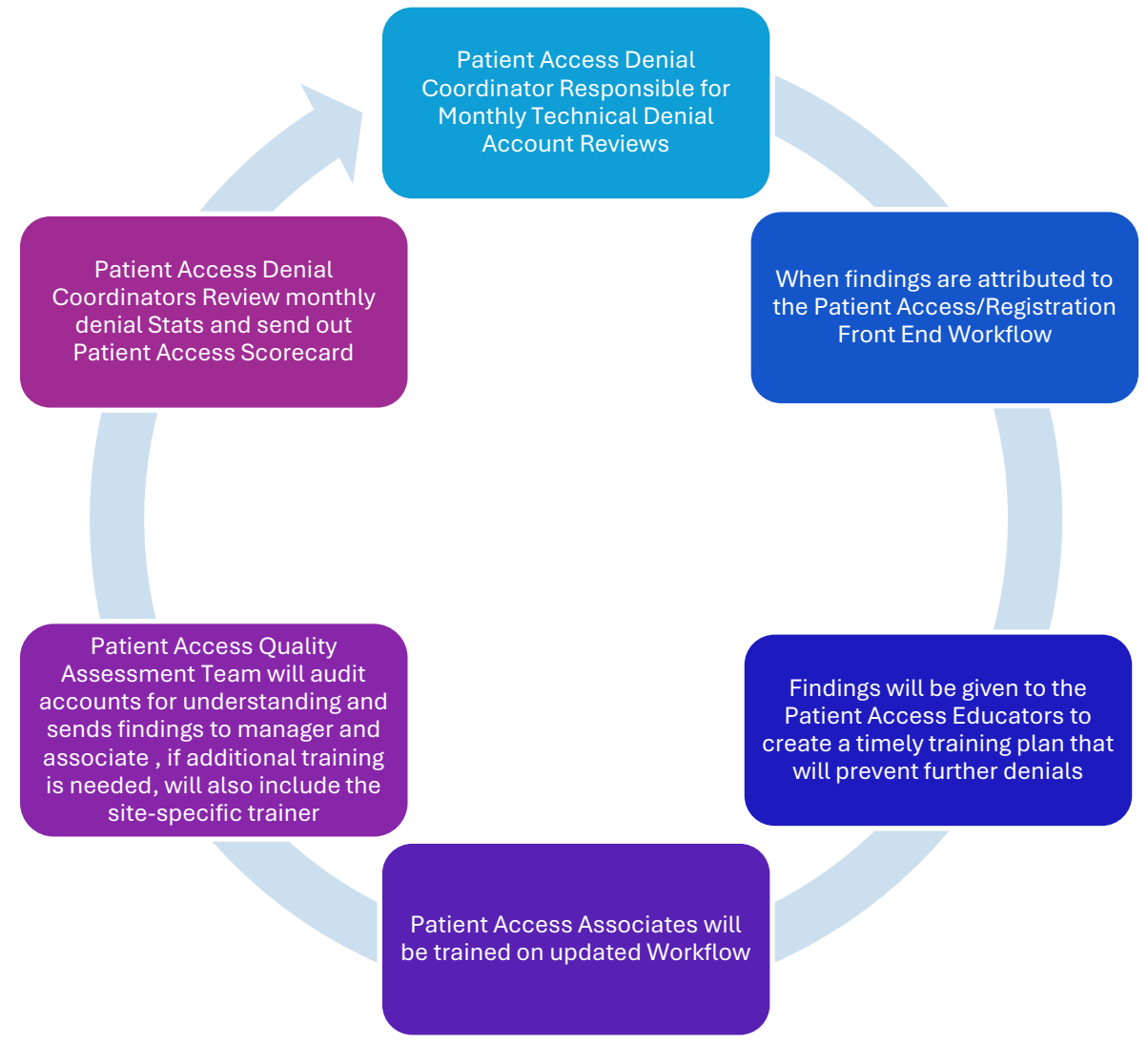


• Case Study

- PATIENT SENT TO ER BY PODIATRIST
- QUICK REG WITH JAI
- REG NOTES STATE ALL INFO UPDATED, ID AND INS CARDS SCANNED ONLY JAI INSURANCE CARD SCANNED AT THE TIME OF ER REG
- 8/24/22 - PATIENT WAS ADMITTED
- 8/25/22 - FAX SENT TO JAI FOR AUTHORIZATION
- 8/30/22- JAI APPROVAL # IA83625F830 2 DAYS
- 8/30/22 - JAI BILLED
- 9/4/22 - OLIVE DISCOVERY – AETNA
- 9/4/22 - AETNA BILLED
- 9/22/22 - AETNA DENIED FOR NO AUTH
- PATIENT DID NOT PROVIDE ALL INSURANCE INFORMATION

FY24 Patient Access Quality Assessment, Education, Training and Denials Mitigation Workflow

Sustaining Positive Trends and Quickly Identify New Ones



Denial Example #1

- CO-CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.

Eligibility Medicaid Rlts

Patient Demo/Plan **Patient Demo/Insurance** Subscriber/Family Payer

Patient Information Eligibility Results

Name:

SSN:

DOB: 01/14/1972 01/14/1972

Address: 409 STEFAN CT 689 OLD WAUGH CHAPEL R

BALTIMORE,MD 21222 ODENTON,MD 211130000

Payer: MEDICAID MD MARYLAND MEDICAID

Cert No.: 43601153100

Eff From: To: To:

Ins Type: Medicaid

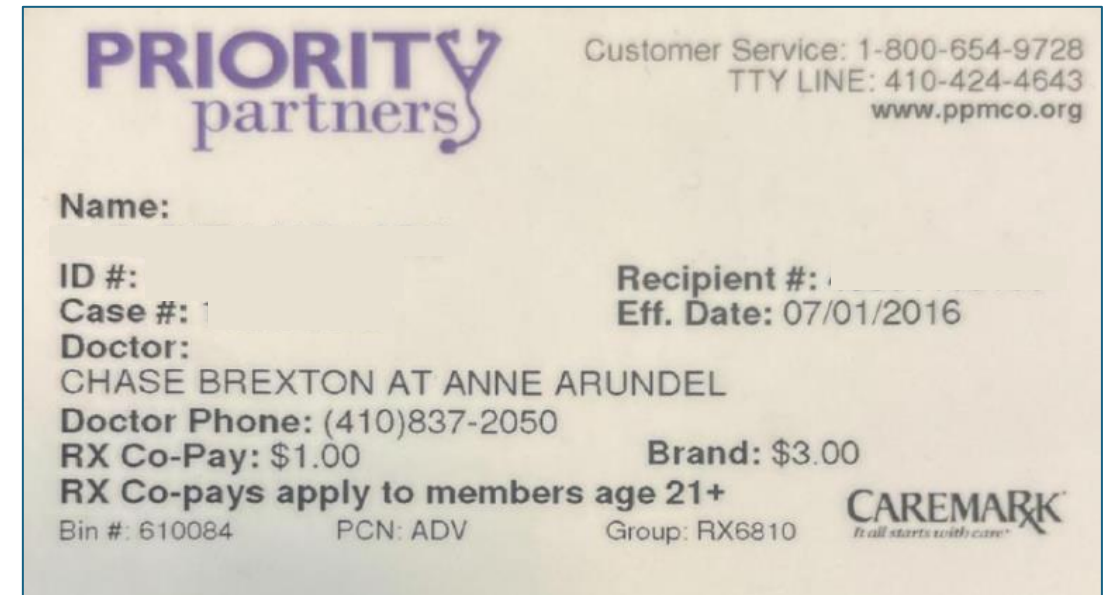
MCO Payer: **PRIORITY PARTNERS**

PCP:

PCP Tel: 8006549728

Status: Mixed

Rev'd: 01/04/2023 Outcome: Eligible-Mixed Reviewed Rec'd: 01/04/2023 Svc: 01/04/2023



- What does this mean? This means that the patient has a managed care plan. In the example shown, you can see that eligibility was verified and the results returned with Priority Partners. There is also a scanned copy of the card in the chart. Medicaid should have been removed and the correct FSC for Priority Partners should have been added and attached to the visit.

Denial Example #2

- OA-THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

Eligibility Medicare Rlts

Patient Demo/Plan Patient Demo/Insurance Payer Subscriber/Family

Patient Information Eligibility Results

Name:

DOB:

Address:

Payer: MEDICARE PART B CMS

Cert No.:

Eff From: 09/01/2011 To: 09/01/2011 DoD: 01/17/2023

Ins Type: Medicare Part B Medicare Part B

Subscriber:

Prim Payer: CAREFIRST OF
Medicare Secondary Working Aged Beneficiary

Prim Descr:

Status: Mixed

Rev'd: 01/19/2023 Outcome: Eligible-Mixed Reviewed Rec'd: 01/17/2023 Svc:

[B-Benefits](#) [E-Edit >](#) [V-View >](#) [R-Review >](#) [A-Variance](#) [B-View 270 Request](#)

Eligibility Medicare Rlts

Patient Demo/Plan Patient Demo/Insurance Payer Subscriber/Family

Patient Information Eligibility Results

Name:

DOB:

Address:

Payer: CMS

Cert No.:

Eff From: 02/01/2016 To: 01/26/2023

Ins Type: Medicare Part B Medicare Part B

Subscriber:

Prim Payer: ANTHEM, INC.
Medicare Secondary Working Aged Beneficiary

Prim Descr:

Status: Mixed Appt: 45538056

Rev'd: Outcome: Rec'd: 01/26/2023 Svc:

[B-Benefits](#) [E-Edit >](#) [V-View >](#) [R-Review >](#) [A-Variance](#) [B-View 270 Request](#)

- In these two examples we can see that eligibility has returned Medicare as secondary. Each example lists who the primary carrier is. Ask the patient if they have other insurance and check the order of your insurances prior to checking in the patient.

Denial Example #3

- CO-CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR. THIS CHANGE EFFECTIVE

Eligibility Medicare Rlts

Patient Demo/Plan **Patient Demo/Insurance** Payer Subscriber/Family

Patient Information		Eligibility Results	
Name:	<input type="checkbox"/>		
DOB:	<input type="checkbox"/>		
Address:	<input type="checkbox"/>		
Payer:	MEDICARE PART B	CMS	
Cert No.:			
Eff From:	To:	<input type="checkbox"/> 01/01/2020	<input type="checkbox"/> To: 02/07/2023
Ins Type:	Medicare Part B	Medicare Part B	
Subscriber:	<input type="checkbox"/>		
Prim Payer:	<input type="checkbox"/>		
Prim Descr:			
		SIERRA HEALT Preferred Provider Organization (PPO)	

Status: Mixed

Rev'd: 02/07/2023 Outcome: Eligible-Mixed Reviewed Rec'd: 02/07/2023 Svc:

[B-Benefits](#) [E-Edit >](#) [V-View >](#) [R-Review >](#) [A-Variance](#) [S-View 270 Request](#)

United Healthcare **SAMBA FEDERAL HEALTH PL**

Health Plan (80840): **911-87726-04**

Member ID: _____ Group Number: _____

Member: _____

Payer ID: 87726

Standard Option

MedicareRx
Prescription Drug Coverage X

RxBIN: 610097
RxPCN: 9999
RxGrp: MPDURS

Copay: PCP \$0
Spec \$0

ER \$0

H2001-861-000

UnitedHealthcare Group Medicare Advantage (PPO)
Plan pays up to Medicare Limiting Charges.

- The patient has a Medicare Advantage Plan
 - Medicare Advantage Plans replace traditional Medicare
- Both Medicare and the Advantage Plan should not be listed in IDX

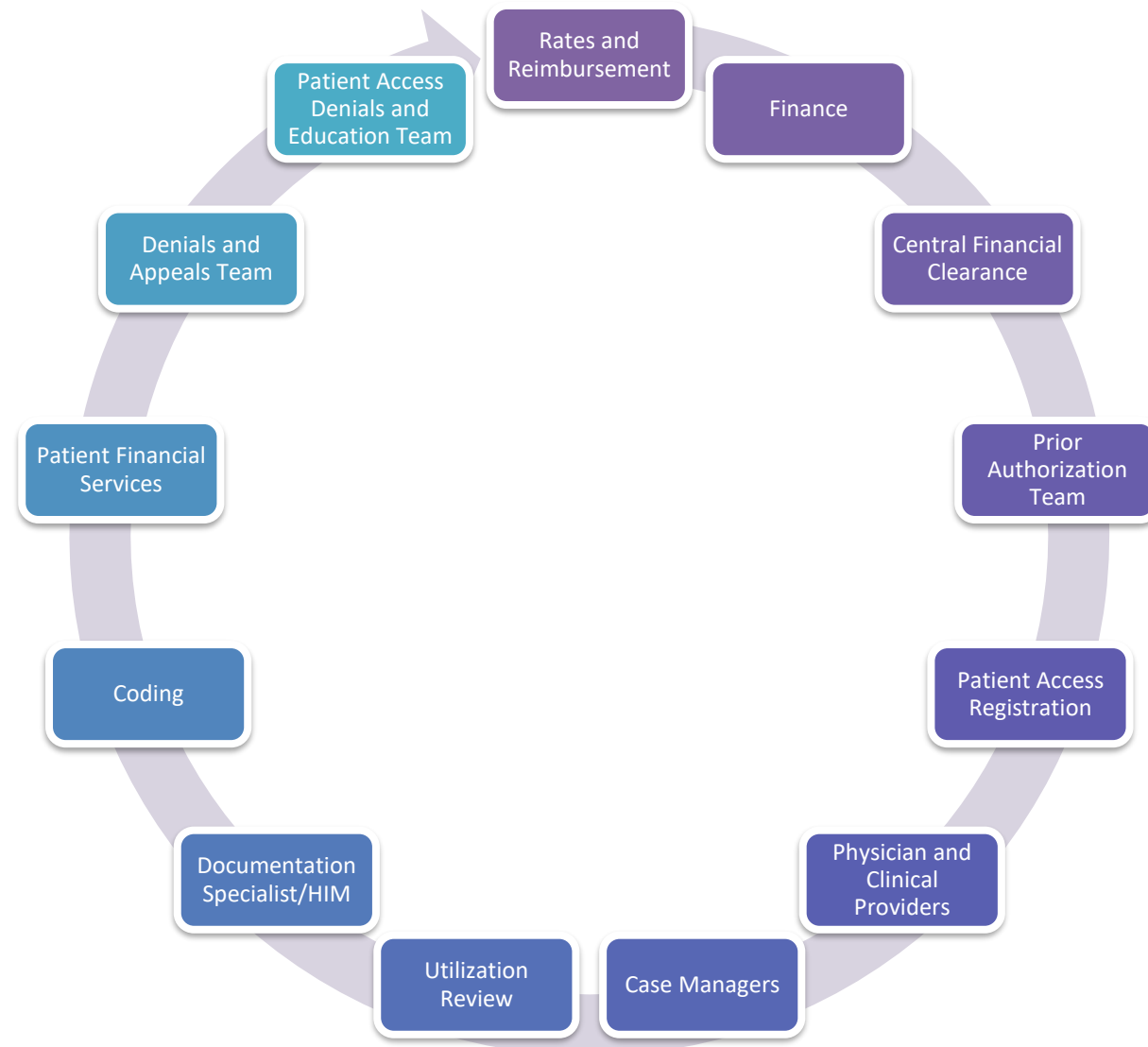
Root Causes - Defined

- Appeal Not worked Timely – Items that should have been appealed but are now Past Statute of Limitations (PSL) to appeal.
- Authorization Date of Service Mismatch – Authorization was obtained but services are outside the dates on the authorization.
- Behavioral vs Medical Insurance – Patient is treated on Behavioral Health unit, when insurance is billed, the claim is denied stating that the claim should be paid by the Medical insurance. Medical insurance is billed, and states claim should be paid by the Behavioral Health insurance.
- Billing Error – Insurance requested a split bill for ER visit & Ancillary Services – Not rebilled correctly
- Biopsy Mismatch – Ordered Imaging Biopsy is different from Biopsy performed
- Blue Choice-No Auth Obtained – Auth was not obtained – Blue Choice is a true HMO plan; all services require an authorization
- Breast Biopsy – Breast Biopsies done in our Breast Center are preformed at MFSSMC lab to ensure Continuity of Care.
- Not otherwise Classified/Unclassified Drugs or Unlisted Procedures– Drugs or procedures that are denied that are not posted.
- Case MGMT – Accounts that we feel should be investigated by Case Management
- Capitated Labs – Lab Test that should have been sent to Lab Corp/Quest
- Coordination of Benefits (COB) – Denial based on Primary vs. Secondary Coverage (Typically payer sends notification to patient to update records.)
- Denied CPT/Auth Mismatch – Authorization requested for CPT Code when billed the CPT Code is different (ex: Diagnostics vs. Screening)
- Ectopic Study – Patients that are seen in the Emergency Room or in OBE and an Ectopic Pregnancy is suspected. The patient receives 2-3 pregnancy test after the initial emergency visit. These are preformed in the hospital lab, regardless of insurance guidelines, to ensure Continuity of Care.
- ER AMA/LOWT – Patients seen in the emergency room and left Against Medical Advice (AMA) and patients that had testing performed while in Triage and Left Without Treatment (LOWT)
- Experimental/Investigational – Commercial Insurances denial reason when the diagnosis code billed does not support the procedure code billed. (equivalent to Medicare Local Medical Review Policy (LMRP).
- Insurance Issue – Internal Insurance Company Errors
- JAI No Referral – JAI insurance requires a referral for all services.
- Kaiser – No Auth Obtained – Kaiser was not notified of admission (Pulled these out to better identify any Kaiser issues)
- Kaiser Secondary – Kaiser is the secondary insurance, and no authorization was obtained. (Pulled these out to better identify any Kaiser issues)
- Late Insurance capture (after D/C or Admission)
- MISC – Cases that need internal review to understand the root cause
- MPC RAD Therapy -Maryland Physicians Care (MPC) Radiation Therapy Denial (pulled these out to ensure we are receiving payment for the calibration of the machine.
- NDC Issue – National Drug Code Denial
- No Auth Obtained - Services that requires an authorization but not obtained
- Non-Par Insurance – Billing facility is out of network with the billed insurance (Authorization and/or a Single Case Agreement (SCA) is required
- Nursing Home Labs – Labs drawn at the Nursing Home and brought to the hospital lab.
- Oncology Labs – Medically Necessary Lab services provided the day of Oncology treatment when patient has a Capitated Plan
- Paid – Negatives that are true payments and not adjustments.
- PAT/SDT – Pre-admission and Same Day Testing that are done up to 5 days prior to a surgery scheduled at a MedStar facility.
- Patient Access Education – Cases denied for registration related reasons
- Patient Issue – Patient name/DOB on file with the insurance company does not match the legal demographics used to bill for services.
- Site of Service – Insurance has carved out the service to a free-standing location, service did not meet medical necessity to be done in an outpatient hospital
- Status Change – Patient status changed that require an authorization
- Sterilization/Hysterectomy Form – Maryland Medicaid and all Medicaid products require a specialized consent form when a patient is scheduled for any service that will result in sterilization. There is a separate form for a Hysterectomy.
- System Issue – Any issue that originated with what the team perceives as an internal system failure.
- Timely Notification – Insurance was not notified of admission within the contractual time frame
- To Be Appealed – Cases that we feel are appealable
- UHC Dual Plan Project – Sent to Managed Care for Payment Reconsideration
- Under Review – Accounts that are pending review
- Units on Auth Exceeded – Authorization of File but not timely reviewed to extend

Denial Workgroups and Committees

Denials Improvement Sub-groups

- ED Collaborative - Local Initiative
 - 67% of Patient Access Denials are from the ER
- High Dollar Technical Denials
- Late Insurance Update - Local Initiative
- MD Managed Care Denied Days Past Statute of Limitations - System Initiative
- Oncology No Authorization
- LMRP
- ACM Optimization Group
- Policy Update Project
- Workflow Reviews



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SMS Outpatient	88,276	75,370	45,798	70,800	280,244
IDX Outpatient	50,899	44,903	11,700	9,293	116,795
ER Registration	46,447	31,019	33,767	36,650	147,883
Total	218,732	167,406	104,948	133,487	624,573

Registration Accuracy Rates***	FSH	GSH	HHC	UMH	BAL Region
SMS	1,036	1,063	764	1,298	4,161
IDX	467	466	67	120	1,120
Total	1,503	1,529	831	1,418	5,281
Accuracy Rate	99.31%	99.09%	99.21%	98.94%	99.15%

Gross Charges	\$693,180,578	\$325,924,024	\$224,154,232	\$509,909,599	\$1,753,168,433
Technical Denials Count	3,354	1,948	942	1,576	7,820
Technical Denials Dollars	<u>\$4,267,890</u>	<u>\$1,901,009</u>	<u>\$1,549,000</u>	<u>\$3,080,000</u>	\$10,797,899
% of Denials	0.62%	0.58%	0.69%	0.60%	1.00%
Denial Count/Registration Count	1.53%	1.16%	0.90%	1.18%	1.25%

Thank you!

