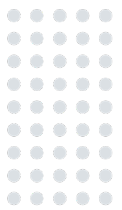


Best Practice Denials Management to Optimize Reimbursement

Presented by Sarah Mendiola, Esq., LPN, CPC, CPCO

February 17, 2021

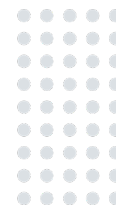
5 Keys to Best Practice Denials Management



1. Assessing Your Resources
2. Ensuring All Denials Are Properly Identified
3. Refining Your Process
4. Maximizing Appeal Quality
5. Tracking Your Results



Assessing Your Resources

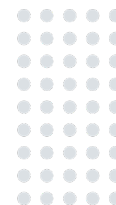


Organizations have a few options for ensuring they have the appropriate resources to effectively manage denials, each of which have their own benefits.

These include:

- Allocating internal staff;
- Outsourcing; or
- Creating a hybrid of the two





The Cloudmed Process

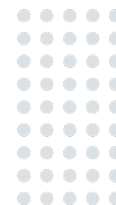
- **Step 1** - Document pull down & loading into proprietary software system - **timeframe appeal!**
- **Step 2** - Root Cause Analysis
 - Review conducted by an Attorney or Senior Analyst
 - A thorough review of all available documentation including contract, provider manual, Federal & State law and/or applicable payer policies, etc.
 - Contact health plan if appropriate
- **Step 3** - Clinical Review and Appeal Preparation
- **Step 4** - Appeal Review
 - Attorney or Senior Analyst ensures the appeal is complete with contract, State or Federal law and that the argument is clear and concise
- **Step 5** - Follow Up to Confirm Receipt & Payer Decision
- **Step 6** - Follow Up for payment
- **Step 7** - Additional Avenues of Pursuit (ALJ hearing, provider rep, external appeal)

Internal Assessment - Staffing

- Evaluate the availability of staff to manage denials
- Establish processes that effectively identify denial types that originate in all areas across the organization:
 - HIM
 - PFS
 - Case Management/Utilization Management



If possible, allocate staff internally **specifically** for appeals.



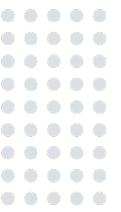
Internal Assessment - Training

- Evaluate current ability of team members to recognize the different types of denials and their nuances
 - Is there already someone in each department who can be appointed to your Denials Management Team?
- Evaluate need for additional training in denials management
- Evaluate cost-effectiveness of training and ongoing education for staff



Assigning a point person for each particular payer ensures that all staff have a resource for denial related questions!

Internal Assessment - Volume

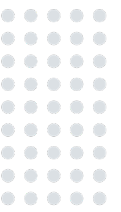


- Evaluate the number of denials you receive
 - Compare volume across departments and overall
- Determine if your Staff has the ability to handle the volume being directed at them



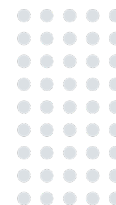
Appeals quality can suffer if volume exceeds available internal resources!

Internal Assessment - Quality Check

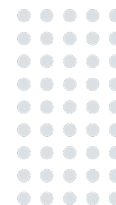


- Sample some of the appeals being filed as a baseline for assessing overall quality
- If staff are not dedicated solely to denials management or appeals, the volume of additional work may make it difficult to produce quality appeals
 - Appeals take careful consideration and time to ensure all aspects of a denial are properly addressed.
- Creating a denials management team goes a long way to addressing quality

Consider Outsourcing



- Any gaps in your denial management system will become apparent after a thorough assessment of your internal resources.
- Perhaps you have the resources to address some denials, but not others.
- Outsource those denial areas as necessary



Recommendations for Outsourcing

- Payors who only have one level of appeal
- Second level appeals
- High Dollar Accounts
- Overflow
- Complex contractual or legal issues
- Accounts deemed not viable for appeal by your current appeals staff
- All accounts that are not regularly appealed
- Appeal rights have been exhausted

Ensuring All Denials Are Properly Identified



- Figure out the **ROOT CAUSE** of the denial.
 - Administrative, Clinical, Coding/Billing, Hybrids

Common Admin Denials:

- Lack of Pre-authorization/ Authorization
- Untimely Claim Filing
- No Referral from PCP
- COB

Common Clinical Denials:

- No Medical Necessity
- Level of Care
- Readmission*

Common Coding/Billing Denials:

- Diagnosis codes
- Modifiers
- Bundling



Don't Take Denials At Face Value!



Accepting denials at face value, can result in lost revenue. **Always look for the ROOT CAUSE of the denial.** Some examples of ambiguous denials that require investigation:

#1: Remit indicates that the charges are denied as “non-covered charge(s)”.

125 NON-COVERED CHARGE(S)

#2: Remit indicates that the charges are denied as “exceeds fee schedule/maximum allowable”.

CO-45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.

Refining Your Process



- Create a comprehensive denials workflow
- Many different people may be involved in the lifecycle of an appeal

Life of an Appeal

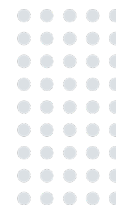


Create a Payer Matrix



- This is an extremely beneficial tool for ALL team members.
 - Claim submission and resubmission timeframes
 - Coordination of Benefits
 - Timeframes for first and second level appeals
 - External appeal options and timeframes
 - Correct addresses, phone numbers, and fax numbers
 - Any key contract terms to assist in the appeals process
 - Availability of retro-authorization and timeframes

Example Payer Matrix



Payer	Claim Submission	Reconsideration/First	Second	Appeal Address
Aetna Contracted all lines	180 days	180 days from denial Reconsideration considered first level	60 days from denial of reconsideration	Attn: Provider Resolution Team PO Box 14079 Lexington, KY 40512-4079 <i>*Must submit appeal form with appeal</i>
Cigna Contracted all lines	180 days	180 days from denial	NO second level	Attn: National Appeals Unit PO Box 188011 Chattanooga, TN 37422
United Healthcare (Commercial Product Lines) Contracted	180 days	365 days from denial	365 days from denial	e-file through UHC portal
United Healthcare (Medicare Products) NOT contracted	1 year Based on Medicare Rules	60 days from denial Submit Waiver of Liability due to Non-Contracted Status	Appeal to be forwarded to Maximus for Independent Review if denied or appeal not completed within 60 days	PO Box 6106 MS CA 124-0157 Cypress, CA 90630-9948

Maximizing Appeal Quality



1. Facts of the Individual Case
 - a. Clinical Issues
 - b. Administrative Issues
 - c. Coding Issues

2. Contract Terms & Provider Manual
 - a. Applicable Policy Bulletins

3. Relevant Law
 - a. State Law
 - b. Federal Law

4. Helpful Legal Theories





Facts of the Individual Case

- Root cause analysis
- Review supporting documentation
- Include :
 - Name, phone #, and department of the person providing benefits and/or authorization
 - Call reference numbers
 - Authorization reference numbers
 - If a procedure was not complied with, explain the reason for the non-compliance

Contract Terms and Provider Manual

- Authorization or Notification requirements
 - Weekends and holidays
 - Calendar days vs. business days
- Retrospective review requirements
- Timely Filing
 - Claims
 - Appeals



Pointing out the insurer's violation of the contract can help overcome denials.

Relevant Federal and/or State Law



- Authorization
 - Modification of authorization, delivery/newborn, emergency services
- Claims submission
 - Minimum timeframes
- Prompt payment
 - Definition of clean claim, payment time frames, interest penalty
- Mis-verification of benefits
- Internal/External Appeals
- Subrogation
- Retroactive denials/ Retractions
- Notice prejudice
- Lien laws
- Pre-existing conditions
- Emergency Services
 - State law definitions, EMTALA
- Continuation of Benefits
- ERISA
- Coordination of benefits
- Automatic newborn coverage
- Experimental treatment
 - Workers compensation, Third Party Liability

Federal vs. State Law Application

Type of Plan	Controlling Law
Fully insured (Insurance)	State
Self-funded (Claims paid by employer group)	Federal
Medicaid/Medicaid MCOs	State
Medicare	Federal
Medicare Advantage	Federal

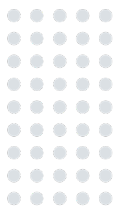
Helpful Legal Theories



- Course of Dealing
- Misrepresentation
- Detrimental reliance

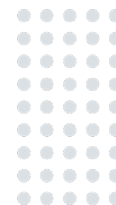
“But for” or without the affirmative action on the part of the insurer, the provider would not have provided the medically necessary services.

Best Practice Denial Analysis Problem #1



St. Elsewhere Hospital rendered medically necessary services to Jane Doe from 10/15/20 – 10/16/20. Jane Doe was admitted through the ED after arriving via ambulance. A claim is timely submitted to ABC Insurance on 11/01/20. On 12/28/20, ABC denied the claim for lack of authorization/notification.

What are our best arguments?



Analysis - Maximizing Appeal Quality

Facts of the Individual Case

- Patient came in through ED
- Was this emergent
- Inability to obtain insurance info
- Inability to obtain authorization

Contract Terms & Provider Manual

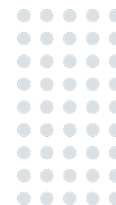
- Plan specific
- Retrospective review

Relevant Law

- EMTALA
- ED services do not require authorization to stabilization

Helpful Legal Theories

- Course of Dealing

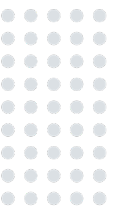


Actual Contract Terms!

Payor shall not deny or reduce payment for any Medically Necessary Covered Services based on Hospital's failure to comply with any administrative or notification requirements...

In the event that the lack of authorization resulted from action or inaction by Payor or by Hospital, **then Payor shall reimburse Hospital for all Medically Necessary Covered Services rendered to this Member.**

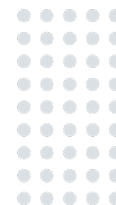
Best Practice Denial Analysis Problem #2



Details from the Clinical Review

The request tells us you went to the hospital for a seizure. The plan clinical criteria considers a full hospital admission for seizures medically necessary when severe problems exist. These might include brain problems such as a stroke, tumor, or continued seizures. The information we have does not show you have these or other severe problems. For this reason, the request for full admission is denied as not medically necessary. We based our decision using the MCG guideline called Seizure (ORG: M-327).

Analysis - Maximizing Appeal Quality



Facts of the Individual Case

- Services met Milliman (MCG)
- Authorization was denied, but the plan only considered the admission documentation, not the entire record

Contract Terms & Provider Manual

- Plan specific
- Clinical Policies

Relevant Law

- Emergent admission?

Helpful Legal Theories

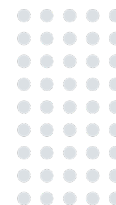
- Guidelines like Milliman have a disclaimer: meant to be a screening tool and not a substitute for clinical judgment.
- Did a qualified Physician actually weigh in on decision?

Tracking Results



- Monitor and Measure your results
 - Detailed Payer “Report Cards”
 - Identifying denial trends
 - Physician Report Card for internal use
 - Establishing executive level reconciliation meetings with Payers





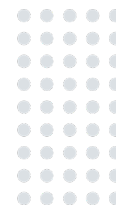
Tracking Your Appeals Record

- How to develop a thorough Payer Report Card:
 - Track your appeals in real time, from drafting to resolution.
 - Consider separate tracking for administrative denials vs. clinical denials, and then comparing the end results.
 - Create reports that track:
 - Number of denials
 - Denial type
 - Including the department appealing the denial
 - Overturn rate




Outpatient Reporting Examples

Example – Top Denied Codes (1 Payer)



J1745 - Injection, infliximab, excludes biosimilar, 10 mg



Denial Reason	Cases	Referred	Cases Overturned	\$ Overturned	# Open Cases	% Cases Overturned
No Authorization	74	\$ 743,467.21	48	\$ 419,012.96	23	94%
Medical Necessity	7	\$ 44,329.09	6	\$ 33,191.64	1	100%
Other	2	\$ 20,082.54		\$ -	2	
J1745 Total	83	\$ 807,878.84	54	\$ 452,204.60	26	95%

J9035 - Injection, bevacizumab, 10 mg

Denial Reason	Cases	Referred	Cases Overturned	\$ Overturned	# Open Cases	% Cases Overturned
No Authorization	17	\$ 417,724.39	14	\$ 363,906.96	3	100%
Medical Necessity	8	\$ 304,773.12	6	\$ 123,729.12	2	100%
J9035 Total	25	\$ 722,497.51	20	\$ 487,636.08	5	100%


J9355 - Injection, trastuzumab, 10 mg

Denial Reason	Cases	Referred	Cases Overturned	\$ Overturned	# Open Cases	% Cases Overturned
No Authorization	26	\$ 480,206.40	11	\$ 191,551.76	15	100%
Medical Necessity	2	\$ 34,724.66	1	\$ 24,682.56	1	100%
J9355 Total	28	\$ 514,931.06	12	\$ 216,234.32	16	100%

J9299 - Injection, nivolumab, 1 mg

Denial Reason	Cases	Referred	Cases Overturned	\$ Overturned	# Open Cases	% Cases Overturned
Medical Necessity	12	\$ 243,426.71	3	\$ 44,458.88	9	100%
No Authorization	12	\$ 182,907.59	6	\$ 98,048.90	3	
J9299 Total	24	\$ 426,334.30	9	\$ 142,507.78	12	75%

70553 - Diagnostic Radiology (Diagnostic Imaging) Procedures of the Head and Neck



Denial Reason	Cases	Referred	Cases Overturned	\$ Overturned	# Open Cases	% Cases Overturned
No Authorization	80	\$ 300,101.47	37	\$ 44,458.88	37	86%
Medical Necessity	14	\$ 52,000.82	8	\$ 98,048.90	5	89%
70553 Total	94	\$ 352,102.29	45	\$ 142,507.78	42	87%

Example – Top Denied Codes (Multiple Payer Comparison)

Payer Report Card CPT XXXX: Description

Payers	Denial Reason	Total Cases Referred	Total Amt Referred	Open	Closed	# Cases Overturned	% Cases Overturned	Amt Referred on Closed Accounts	Amt Recovered	% Dollar Amt Overturned (Closed)
Payer A										
	Lack of Authorization	25	\$650,000.00	5	20	17	85%	\$500,500.00	\$425,425.00	85%
	Lack of Medical Necessity	4	\$100,000.00	0	4	3	75%	\$100,100.00	\$75,075.00	75%
	Experimental / Investigational	16	\$400,000.00	8	8	6	75%	\$200,200.00	\$150,150.00	75%
	Total	45	\$1,150,000.00	13	32	26	81%	\$800,800.00	\$650,650.00	81%
Payer B										
	Lack of Authorization	2	\$15,000.00		2	2	100%	\$15,000.00	\$15,000.00	100%
	Lack of Medical Necessity	8	\$200,000.00	3	5	4	80%	\$160,000.00	\$120,000.00	75%
	Total	10	\$215,000.00	3	7	6	86%	\$175,000.00	\$135,000.00	77%
Payer C										
	Lack of Authorization	1	\$5,000.00		1	1	100%	\$5,000.00	\$5,000.00	100%
	Lack of Medical Necessity	8	\$150,000.00	2	6	4	67%	\$100,000.00	\$80,000.00	80%
	Total	9	\$155,000.00	2	7	5	71%	\$105,000.00	\$75,000.00	71%
Grand Total:		64	\$1,520,000.00	18	46	37	80%	\$1,080,800.00	\$860,650.00	80%

Payer Report Card CPT XXXX: Description

Payers	Denial Reason	Total Cases Referred	Total Amt Referred	Open	Closed	# Cases Overturned	% Cases Overturned	Amt Referred on Closed Accounts	Amt Recovered	% Dollar Amt Overturned (Closed)
Payer A										
	Lack of Authorization	10	\$200,000.00	4	6	4	67%	\$150,150.00	\$100,100.00	67%
	Lack of Medical Necessity	5	\$100,000.00	1	4	3	75%	\$100,100.00	\$75,075.00	75%
	Experimental / Investigational	5	\$400,000.00	1	4	3	75%	\$100,100.00	\$75,075.00	75%
	Total	20	\$700,000.00	6	14	10	71%	\$350,350.00	\$250,250.00	71%
Payer B										
	Lack of Authorization	7	\$650,000.00	4	3	1	33%	\$75,075.00	\$25,025.00	33%
	Lack of Medical Necessity	5	\$100,000.00	0	5	4	80%	\$125,125.00	\$100,100.00	80%
	Experimental / Investigational	3	\$400,000.00	1	2	1	50%	\$50,050.00	\$25,025.00	50%
	Total	15	\$1,150,000.00	5	10	6	60%	\$250,250.00	\$150,150.00	60%
Payer C										
	Lack of Authorization	6	\$650,000.00	2	4	3	75%	\$100,100.00	\$75,075.00	75%
	Lack of Medical Necessity	3	\$100,000.00	1	2	2	100%	\$50,050.00	\$50,050.00	100%
	Experimental / Investigational	1	\$400,000.00	0	1	1	100%	\$25,025.00	\$25,025.00	100%
	Total	10	\$1,150,000.00	3	7	6	86%	\$175,175.00	\$150,150.00	86%
Grand Total:		45	\$3,000,000.00	14	31	22	71%	\$775,775.00	\$550,550.00	71%

Example – Top Denied Codes (Lack of Authorization Drill Down)



73721 - MRI Lower Join - With Contrast

Root Cause	Cases	Denied Amount	Recovered Amount	Success Rate
Alternate Procedure Authorized	6	\$ 6,871.65	\$ 5,840.90	85%
Authorization Obtained for Less Complex Procedure	116	\$ 153,087.93	\$ 134,472.44	88%
Authorization on File	1	\$ 5,416.00	\$ 5,416.00	100%
Coordination of Benefits	5	\$ 5,831.00	\$ 5,831.00	100%
Failure to Authorize	17	\$ 21,429.68	\$ 10,322.25	48%
Misquoted Authorization Requirements	7	\$ 3,168.00	\$ 2,521.09	80%
Total	152	\$ 195,804.26	\$ 164,403.68	84%

64483 - Injection Foramen Epidural

Root Cause	Cases	Denied Amount	Recovered Amount	Success Rate
Authorization on File	1	\$ 1,256.00	\$ 1,256.00	100%
Failure to Authorize	103	\$ 233,156.79	\$ 129,705.12	56%
Misquoted Authorization Requirements	11	\$ 26,845.60	\$ 21,812.05	81%
Total	115	\$ 261,258.39	\$ 152,773.17	58%



J0897 - Denosumab

Root Cause	Cases	Denied Amount	Recovered Amount	Success Rate
Authorization on File	5	\$ 4,584.67	\$ 4,584.67	100%
Coordination of Benefits	4	\$ 6,337.33	\$ 6,337.33	100%
Failure to Authorize	25	\$ 33,361.26	\$ 15,306.15	46%
Misquoted Authorization Requirements	64	\$ 84,580.73	\$ 62,691.24	74%
Total	98	\$ 128,863.99	\$ 88,919.38	69%

J1745 - Infliximab

Root Cause	Cases	Denied Amount	Recovered Amount	Success Rate
Authorization on File	2	\$ 9,848.25	\$ 9,848.25	100%
Coordination of Benefits	4	\$ 6,337.33	\$ 3,473.49	55%
Failure to Authorize	25	\$ 33,361.26	\$ 15,292.80	46%
Misquoted Authorization Requirements	34	\$ 161,772.00	\$ 93,578.63	58%
Total	65	\$ 211,318.84	\$ 122,193.17	58%



Inpatient Reporting Examples

Example - Cloudmed Denials Reporting

Accounts Placed

3,950

Count of PCN

Amount Recovered

\$14M

Total Amount Verified

Open Inventory

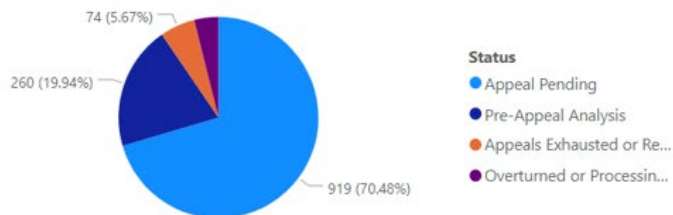
1,304

Count of PCN

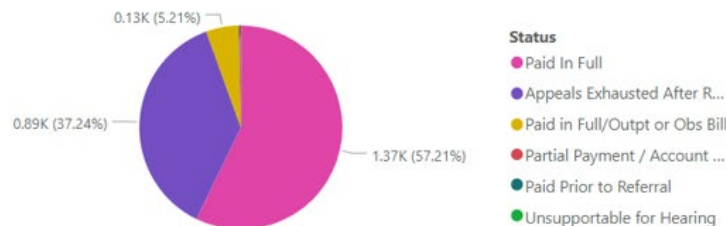
Placements by Month



Open Inventory Status



Closed Inventory Status



Payer Report Card

Denial Insurance Company	Count of PCN	Amount Referred	Total Amount Verified	Average of OTR \$
Aetna Health, Inc.	67	\$1,078,968.94	\$1,035,552.17	90.91%
Aetna Medicare Advantage	116	\$936,121.98	\$840,720.74	91.89%
Anthem BCBS	381	\$7,571,818.93	\$3,820,991.68	56.90%
Anthem BCBS Medicare Advantage	122	\$922,489.88	\$490,919.82	60.36%
Anthem Medicaid	13	\$88,343.02	\$32,326.17	62.50%
Cigna	60	\$953,942.36	\$929,019.30	96.49%
Commercial	14	\$236,228.17	\$173,569.39	75.00%
Commercial Plan	121	\$1,491,605.81	\$1,312,780.96	94.59%
Humana Medicare Advantage	91	\$606,999.69	\$366,678.77	64.37%
Managed Medicaid	430	\$2,574,094.26	\$1,165,991.34	53.42%
Total	2646	\$27,759,430.91	\$14,434,684.18	57.32%

Example - Cloudmed Denials Reporting (Top Denied DRG & LOS)

Accounts Placed

3,950

Count of PCN

Amount Recovered

\$14M

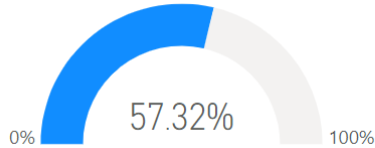
Total Amount Verified

Open Inventory

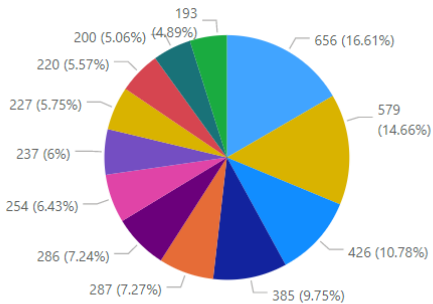
1,304

Count of PCN

Overturn Rate (\$)

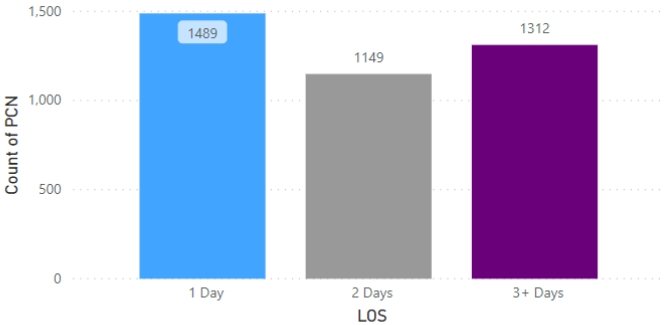


Medical Necessity Denials by DRG



- DRG**
- ESOPHAGITIS, GASTROENT...
 - BRONCHITIS AND ASTHMA
 - PERCUTANEOUS CARDIOV...
 - CHEST PAIN
 - SYNCOPE AND COLLAPSE
 - HEART FAILURE AND SHO...
 - CELLULITIS WITHOUT MCC
 - SIMPLE PNEUMONIA AND ...
 - KIDNEY AND URINARY TR...

Medical Necessity Denials by Length of Stay



Payer Report Card

Denial Insurance Company	Count of PCN	Amount Referred	Total Amount Verified	Average of OTR \$
Managed Medicaid	430	\$2,574,094.26	\$1,165,991.34	53.42%
Anthem BCBS	381	\$7,571,818.93	\$3,820,991.68	56.90%
Medicare Advantage Plan	340	\$2,584,409.95	\$1,308,278.95	60.21%
UHC Medicare Advantage	301	\$2,148,549.09	\$844,832.25	43.88%
Managed Medicaid Local	268	\$1,725,287.91	\$684,310.79	45.34%
UHC	264	\$4,313,657.19	\$1,248,151.45	33.60%
Anthem BCBS Medicare Advantage	122	\$922,489.88	\$490,919.82	60.36%
Commercial Plan	121	\$1,491,605.81	\$1,312,780.96	94.59%
Total	2646	\$27,759,430.91	\$14,434,684.18	57.32%

Example - Cloudmed Denials Reporting Drilldown (Specific DRG)

Accounts Placed

656

Count of PCN

Amount Recovered

\$2M

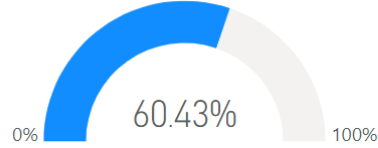
Total Amount Verified

Open Inventory

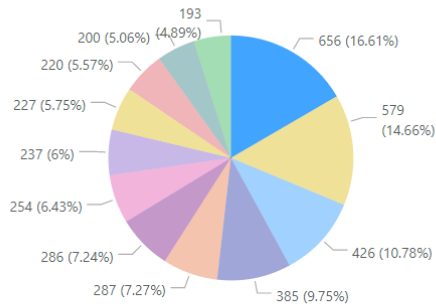
231

Count of PCN

Overturn Rate (\$)



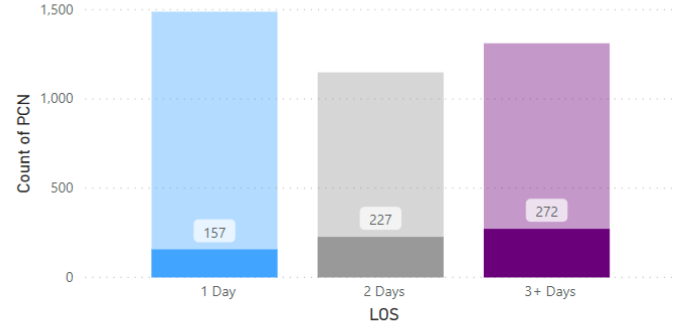
Medical Necessity Denials by DRG



DRG

- ESOPHAGITIS, GASTROENT...
- BRONCHITIS AND ASTHMA
- PERCUTANEOUS CARDIOV...
- CHEST PAIN
- SYNCOPE AND COLLAPSE
- HEART FAILURE AND SHO...
- CELLULITIS WITHOUT MCC
- SIMPLE PNEUMONIA AND ...
- KIDNEY AND URINARY TR...

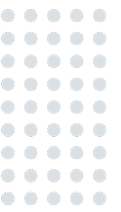
Medical Necessity Denials by Length of Stay



Payer Report Card

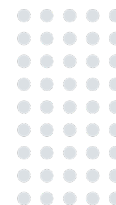
Denial Insurance Company	Count of PCN	Amount Referred	Total Amount Verified	Average of OTR \$
UHC Medicare Advantage	78	\$537,300.94	\$162,199.52	38.81%
Medicare Advantage Plan	65	\$454,919.82	\$198,694.78	52.94%
Anthem BCBS	62	\$906,355.00	\$699,083.50	74.58%
UHC	53	\$735,169.37	\$207,409.97	40.00%
Managed Medicaid Local	33	\$223,377.08	\$112,178.87	62.07%
Aetna Medicare Advantage	26	\$186,008.74	\$159,123.06	87.50%
Anthem BCBS Medicare Advantage	23	\$175,082.90	\$94,935.30	59.09%
Managed Medicaid	19	\$145,546.16	\$41,258.36	69.23%
Total	425	\$4,083,328.78	\$2,197,696.14	60.43%

Physician Report Card



- Track clinical denials by department and, if possible, by physician.
- The Payer Report Card shows which Payers we need to look out for; a Physician Report Card can track internal documentation issues for prevention efforts.

Physician Report Card Example



Attending Physician	Denial/Variance Reason	Cases Referred	Amount Referred	Amount Recovered
Dr. Who	01 - Pt required a lower level of care	5	\$20,000.00	\$15,000.00
	02 - Observation Status Appropriate	2	\$10,000.00	\$3,000.00
	03 - No Medical Necessity	1	\$60,000.00	\$50,000.00
	06 - Delay in Procedure	1	\$5,000.00	\$0.00
	22 - Failed to Provide Medical Records	3	\$15,000.00	\$15,000.00
	25 - Late/No Notification	1	\$9,000.00	\$9,000.00
	77 - Insurer Requesting a Refund	1	\$5,000.00	\$5,000.00
Dr. Who Total		22	\$124,000.00	\$97,000.00
Dr. Whatsit	01 - Pt required a lower level of care	4	\$20,000.00	\$500.00
	02 - Observation Status Appropriate	1	\$5,000.00	\$5,000.00
	03 - No Medical Necessity	2	\$20,000.00	\$5,000.00
	70 - Additional Info Needed By Insurer	1	\$10,000.00	\$0.00
Dr. Whatsit Total		8	\$55,000.00	\$10,500.00
Dr. Which	01 - Pt required a lower level of care	5	\$30,000.00	\$10,000.00
	02 - Observation Status Appropriate	2	\$15,000.00	\$15,000.00
	03 - No Medical Necessity	2	\$10,000.00	\$10,000.00
Dr. Which Total		9	\$55,000.00	\$35,000.00
Dr. Where	01 - Pt required a lower level of care	4	\$10,000.00	\$2,000.00
	03 - No Medical Necessity	2	\$100,000.00	\$80,000.00
	70 - Additional Info Needed By Insurer	1	\$5,000.00	\$5,000.00
	73 - Insurer Stall	1	\$2,000.00	\$2,000.00
Dr. Where Total		8	\$117,000.00	\$89,000.00
Dr. When	01 - Pt required a lower level of care	5	\$50,000.00	\$5,000.00
	02 - Observation Status Appropriate	2	\$10,000.00	\$0.00
	03 - No Medical Necessity	4	\$25,000.00	\$25,000.00
	22 - Failed to Provide Medical Records	3	\$5,000.00	\$5,000.00
	70 - Additional Info Needed By Insurer	1	\$5,000.00	\$5,000.00
Dr. When Total		15	\$95,000.00	\$40,000.00
Grand Total		62	\$446,000.00	\$271,500.00

Executive Reporting



- Best Practice requires executive level reporting that assists in identifying trends in the denials landscape
- Use in tandem with reports benchmarking your results
- These reports should allow an executive to understand, at a glance, what areas in the facility are:
 - Receiving denials
 - Overturn rates (by denial type and level of appeal)
 - Effectiveness of each denial management team member

Executive Summary – Account Overview



Grand Total Recovered Amount (Open & Closed):	\$550,000.00
Overturn Rate - Dollars Brought to Resolution	73.83%
Overturn Rate - Cases Brought to Resolution	75.00%

	Total Referrals	Amount Referred
Total Referrals	500	\$2,275,000.00
Total Appealable Claims	450	\$2,075,000.00

	No. of Claims	Recovered Amount	Approx. Referred Amount
Pre-Appeal Analysis	45		\$195,000.00
Documentation / Information Pending	15		\$145,000.00
Claim or Appeal Being Reviewed by Payer	150	\$4,000.00	\$700,000.00
Overturn or Processing for Payment	15	\$500.00	\$70,000.00
Patient Consent Pending	10		\$40,000.00
Appeals Exhausted or Research in Progress	15	\$15,500.00	\$200,000.00
Total Appealable(Open):	250	\$20,000.00	\$1,350,000.00

Closed Appealable Claims

	No. of Claims	Recovered Amount	Approx. Referred Amount
Paid In Full	149	\$500,000.00	\$625,000.00
Partial Payment / Acct Resolved	1	\$30,000.00	\$50,000.00
Appeals Exhausted	50		\$50,000.00
Total Appealable(Closed):	200	\$530,000.00	\$725,000.00

Non-Appealable Claims

	No. of Claims	Recovered Amount	Approx. Referred Amount
Appeal Untimely or Exhausted Prior to Referral	20		\$70,000.00
Part of Settlement	5		\$30,000.00
No Appealable Issue	10		\$25,000.00
Paid Prior to Referral	10		\$70,000.00
Unsupportable for Appeal	5		\$5,000.00
Total Non-Appealable Claims:	50		\$200,000.00

Executive Summary – Denial Category Summary



Referrals	500	\$2,275,000.00
Appealable Claims	450	\$2,075,000.00

	Overturn Rate
No Authorization	96.26%
Medical Necessity	75.98%
DRG Downcode	38.85%
Billing Error	31.82%

Open Appealable Claims

	No. of Claims	Recovered Amount	Approx. Referred Amount
Billing Error	20	\$1,000.00	\$40,000.00
DRG Downcode	30	\$4,000.00	\$160,000.00
Medical Necessity	100	\$10,000.00	\$850,000.00
No Authorization	100	\$5,000.00	\$300,000.00
Total Appealable(Open):	250	\$20,000.00	\$1,350,000.00

Closed Appealable Claims

	No. of Claims	Recovered Amount	Approx. Referred Amount
Billing Error	5	\$2,500.00	\$10,000.00
DRG Downcode	20	\$50,000.00	\$135,000.00
Medical Necessity	50	\$300,000.00	\$398,000.00
No Authorization	125	\$175,000.00	\$182,000.00
Cases Brought to Resolution	200	\$527,500.00	\$725,000.00

Non-Appealable Claims

	No. of Claims	Recovered Amount	Approx. Referred Amount
Billing Error	10		\$25,000.00
DRG Downcode	10		\$25,000.00
Medical Necessity	10		\$100,000.00
No Authorization	20		\$50,000.00
Total Non-Appealable Claims:	50		\$200,000.00

Summary

- Denials Management is a critical component to maintaining the profitability of the revenue cycle.
- Remember to Implement the 5 Keys to Best Practice Denial Management:
 1. Assess Your Resources
 2. Ensure All Denials Are Properly Identified
 3. Refine Your Process
 4. Maximize Appeal Quality
 5. Track Your Results



Thank You!

Sarah Mendiola, Esq., LPN, CPC, CPCO
sarah.mendiola@cloudmed.com



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