Defense Health Agency
Uniform Business Office

Denials Management
Establishing Best Practices

21 February 2017 0800 – 0900 EST
23 February 2017 1400 – 1500 EST

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Overview

- Military Health System (MHS) Third Party Collection Program (TPCP) Background
- What is a denial?
- Denials across the revenue cycle
- Importance of Denials Management
- Types of claim denials
- Learn how to read and interpret an Explanation of Benefits (EOB)
- Process for handling claim denials
- Denials management best practices
- Tips for tracking denials in ABACUS
- Effective communication with MTF staff and payers
- Appealing denials

- Title 10, United States Code (U.S.C.), Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries

- Title 32, Code of Federal Regulations (CFR), Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Exclusions impermissible
    - Reasonable charges
    - Rights and obligations of beneficiaries
    - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

What is a Denial?

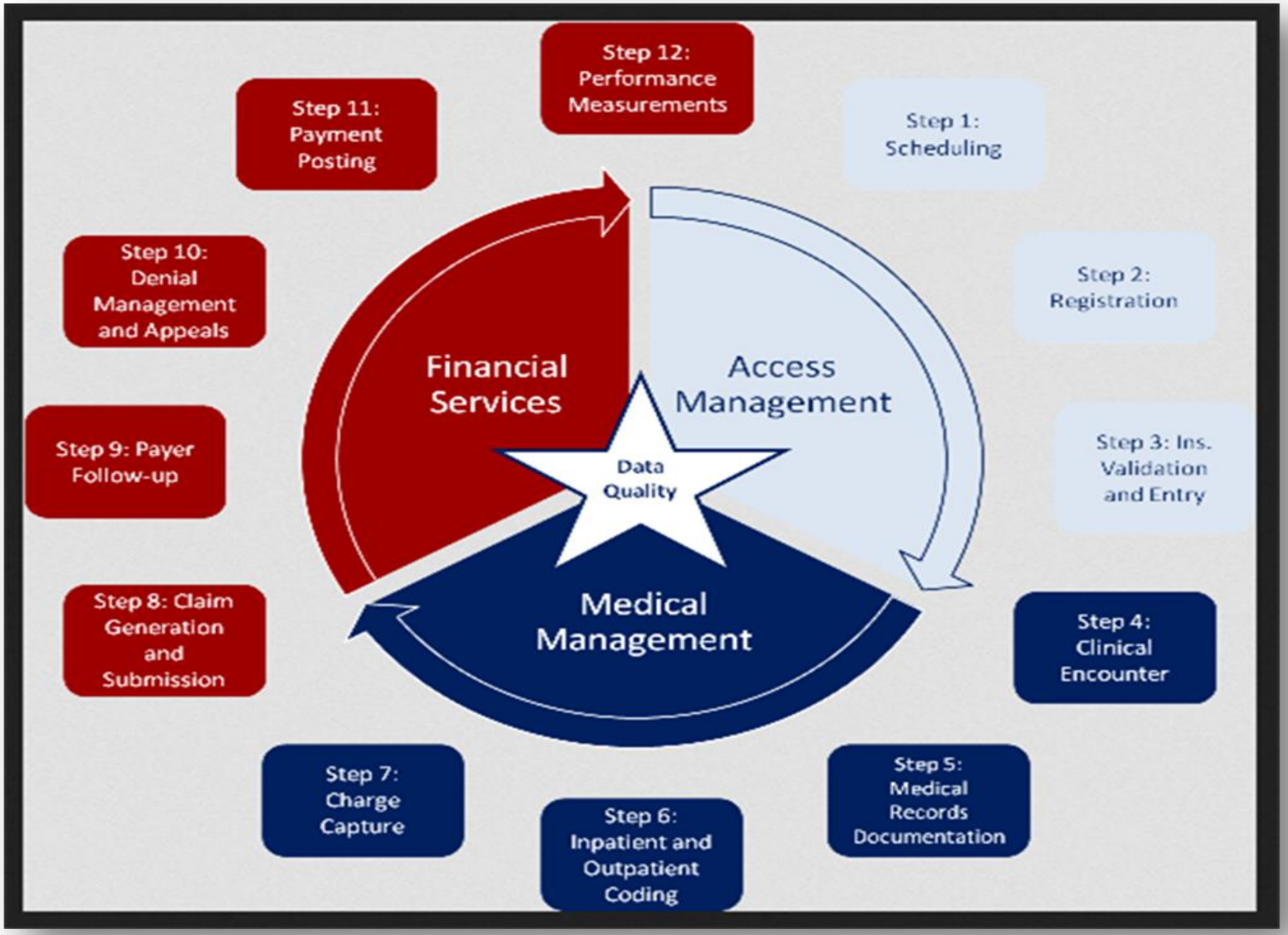
- Health care industry does not have one universal definition of a claim denial:

  - "Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided." Healthcare Financial Management Association(HFMA)

  - "A claim line item or service line item that results in no payment including rejected claims."*

*Denial Management: Key Tools and Strategies For Prevention and Recovery, Pam Waymack

Military Health System (MHS) Revenue Cycle



The Importance of Denials Management

- Why are effective denials management processes so important?
  - Denials have increased significantly as the electronic billing and remittance process becomes increasingly sophisticated
    - Claims have less “human” contact
    - Computer based payment algorithms search for key information according to payer contract requirements
  - The average cost to rework a claim is $25.00 (HFMA)
  - Failing to rework denials results in a loss of revenue that supports your MTF’s operation and maintenance budget
  - Manageable accounts receivable

The Importance of Denials Management, cont.

- In 2015, the DoD Inspector General (IG) performed a review of 6 MTFs to determine if compliance audits of their TPCP were being conducted to monitor missed collection opportunities.
  - Finding: the audits **were not** being conducted; additionally, these specific actions were not being performed*:
    - Initial follow up – 64,345 claims worth $17.3M
    - Documenting write-off rationale – 67,047 claims worth $11.9M
    - Forwarding claims to legal office for collection – 45,812 claims worth $9.2M
    - Obtain pre-certification or pre-authorization - 19,632 claims worth $10.3M
    - Total: 144,930 claims, $112,518,396 billed, $21,685,169 remained uncollected
  - DoD IG Recommendations
    - Conduct an analysis to determine the sufficient time needed to conduct adequate follow up on billed claims for TPCP.
    - Review Uniform Business Office (UBO) resource issues
    - Refer outstanding TPCP claims to legal office as required
    - Update the UBO Manual
    - Establish a quality assurance program that monitors the TPCP and follow up requirements
    - Establish agreements with payers to accept claims for 90-day prescriptions

*FY 2012 – FY 2014 outpatient claims data

"July 24, 2015, Follow-up Audit: DoD Military Treatment Facilities Continue to Miss Opportunities to Collect on Third Party Outpatient Claims"

- Why Is Denials Management So Difficult?
  - Complexity of third-party denials
  - Denial information provided by third-party payers is not standardized
  - Perceived inability to capture the denial data
  - Constantly changing information
  - Requires coordination throughout the revenue cycle
  - Challenging appeals process

Hard Denials

(Appeal required)

- Untimely filing
- Non-covered benefit
- No pre-authorization
- Bundling

Soft Denials

(A temporary or interim denial)

- Missing/inaccurate information
- Charge/coding issues
- Coordination of benefits (multiple coverage)
- Pending itemized bill

Clinical

- Medical necessity
- Alternate setting
- Length of stay exceeds authorization (delay in discharge)

Administrative

- Failure to pre-authorize care
- Lack of clinical information
- Non-covered benefit
- Exclusion denials
- Termination of coverage

- The reason for a denial can be attributed to weaknesses within at least one of the three components of the revenue cycle

Quiz Question #1

- Which type of denial must be appealed?

A) Soft Denial

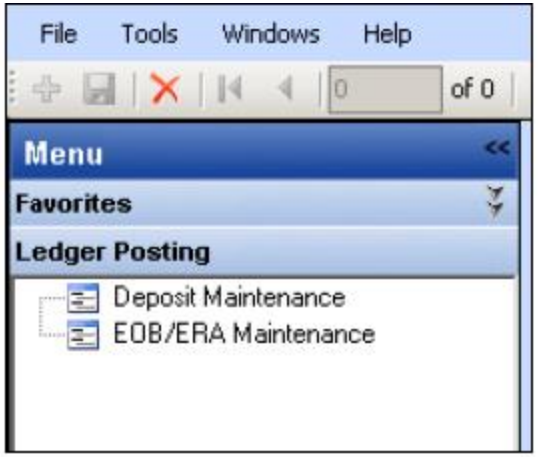
B) Administrative Denial

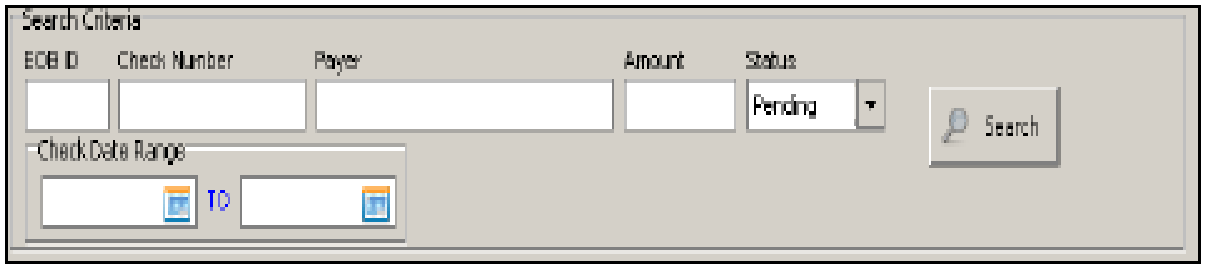
C) Hard Denial

D) Clinical Denial

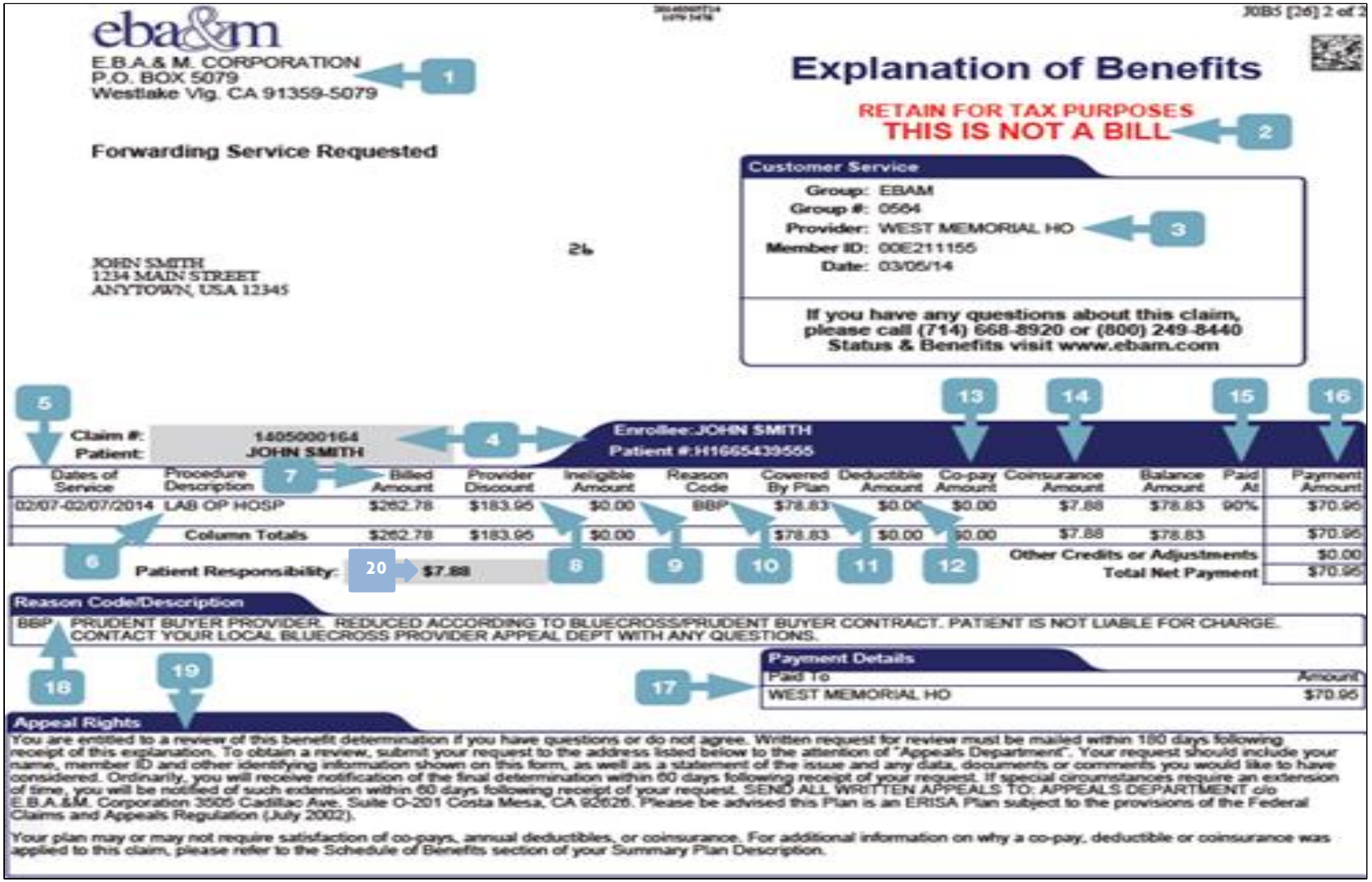
- Definition and Purpose:
  - An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied.
  - The purpose is to provide detailed payment information relative to the claim.

- Electronic EOBs can be viewed and printed from the 835 Viewer
  - Ledger Posting > EOB/ERA Maintenance





Sample EOB



eba&m

E.B.A.& M. CORPORATION
P.O. BOX 5079
Westlake Vlg. CA 91359-5079

1

Forwarding Service Requested

JOHN SMITH
1234 MAIN STREET
ANYTOWN, USA 12345

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

2

Customer Service

Group: EBAM
Group #: 0564
Provider: WEST MEMORIAL HO
Member ID: 00E211155
Date: 03/05/14

3

If you have any questions about this claim, please call (714) 668-8920 or (800) 249-8440
Status & Benefits visit www.ebam.com

5 Claim #: 14050000164
Patient: JOHN SMITH

4

Enrollee:JOHN SMITH
Patient #:H16654339555

13 14 15 16

Dates of Service	Procedure Description	7 Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amt	Paid At	Payment Amount
02/07-02/07/2014	LAB OP HOSP	$262.78	$183.95	$0.00	BBP	$78.83	$0.00	$0.00	$7.88	$78.83	90%	$70.95
	Column Totals	$262.78	$183.95	$0.00		$78.83	$0.00	$0.00	$7.88	$78.83		$70.95

6

Patient Responsibility: 20 $7.88

8 9 10 11 12

Other Credits or Adjustments $0.00
Total Net Payment $70.95

Reason Code/Description

BBP PRUDENT BUYER PROVIDER. REDUCED ACCORDING TO BLUECROSS/PRUDENT BUYER CONTRACT. PATIENT IS NOT LIABLE FOR CHARGE. CONTACT YOUR LOCAL BLUECROSS PROVIDER APPEAL DEPT WITH ANY QUESTIONS.

18 19

17

Payment Details

Paid To	Amount
WEST MEMORIAL HO	$70.95

Appeal Rights

You are entitled to a review of this benefit determination if you have questions or do not agree. Written request for review must be mailed within 180 days following receipt of this explanation. To obtain a review, submit your request to the address listed below to the attention of "Appeals Department". Your request should include your name, member ID and other identifying information shown on this form, as well as a statement of the issue and any data, documents or comments you would like to have considered. Ordinarily, you will receive notification of the final determination within 60 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such extension within 60 days following receipt of your request. SEND ALL WRITTEN APPEALS TO: APPEALS DEPARTMENT c/o E.B.A.&M. Corporation 3505 Cadillac Ave. Suite O-201 Costa Mesa, CA 92626. Please be advised this Plan is an ERISA Plan subject to the provisions of the Federal Claims and Appeals Regulation (July 2002).

Your plan may or may not require satisfaction of co-pays, annual deductibles, or coinsurance. For additional information on why a co-pay, deductible or coinsurance was applied to this claim, please refer to the Schedule of Benefits section of your Summary Plan Description.

Interpreting an EOB, cont.

1) **Payer information** – payer name and mailing address
2) **Standard EOB statement** – "THIS IS NOT A BILL" will be on all EOBs
3) **Payer contact info** – group name, group #, provider name, member ID, claim date, contact phone #
4) **Patient info** – claim #, patient name, enrollee name, patient #
5) **Dates of service** – when the patient received services
6) **Service/product description** – services the patient received from the provider
7) **Charges** – amount billed to the patient and healthcare plan
8) **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment

9) **Amount not covered** – the amount of services/products not covered by the plan
10) **Reason Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full
11) **Covered by plan** – amount covered by healthcare plan
12) **Deductible** – the amount the patient pays toward covered services each year before the third party payer starts paying for services
13) **Copay** – the amount the patient pays the provider for a visit/service
14) **Coinsurance** – what the patient must pay the health plan after the health plan pays the covered percentage
15) **%** – percentage level of benefits for covered services/products
16) **Payment amount** – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered

17) **Total paid by health plan** – total amount paid to provider by payer
18) **Reason Code/Description** – a detailed explanation of reason code
19) **Appeal Rights** – instructions to patient for requesting a review of benefit information
20) **Patient responsibility** – what the patient must pay to the provider of the billed charges after the plan benefits have paid

Quiz Question #2

- What is the purpose of an EOB or Remittance Advice?

A) To provide a pre-authorization for care

B) To provide detailed payment information relative to the claim

C) To provide payment

Process For Handling Denials

- Interpret the EOB to ensure that a valid denial reason has been received
- Determine if the amount needs to be written off
- Determine if denial can be corrected and resubmitted or if the claim requires an appeal
- Engage appropriate departments
- Develop your case based on the payer's guidelines
- Monitor and follow up on corrected or appealed claims

- Early Intervention
  - Respond to denials immediately
  - Establish a timeline for working denials
  - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
  - Monitor and act upon unresolved denials
  - Measure denials and appeal results
  - Follow up on all levels of appeals process
  - Trend issues by payer and reason
- Impact of Best Practices
  - Improved cash flow due to an increase in clean claims and a reduction in denials

How to Establish a Best Practice

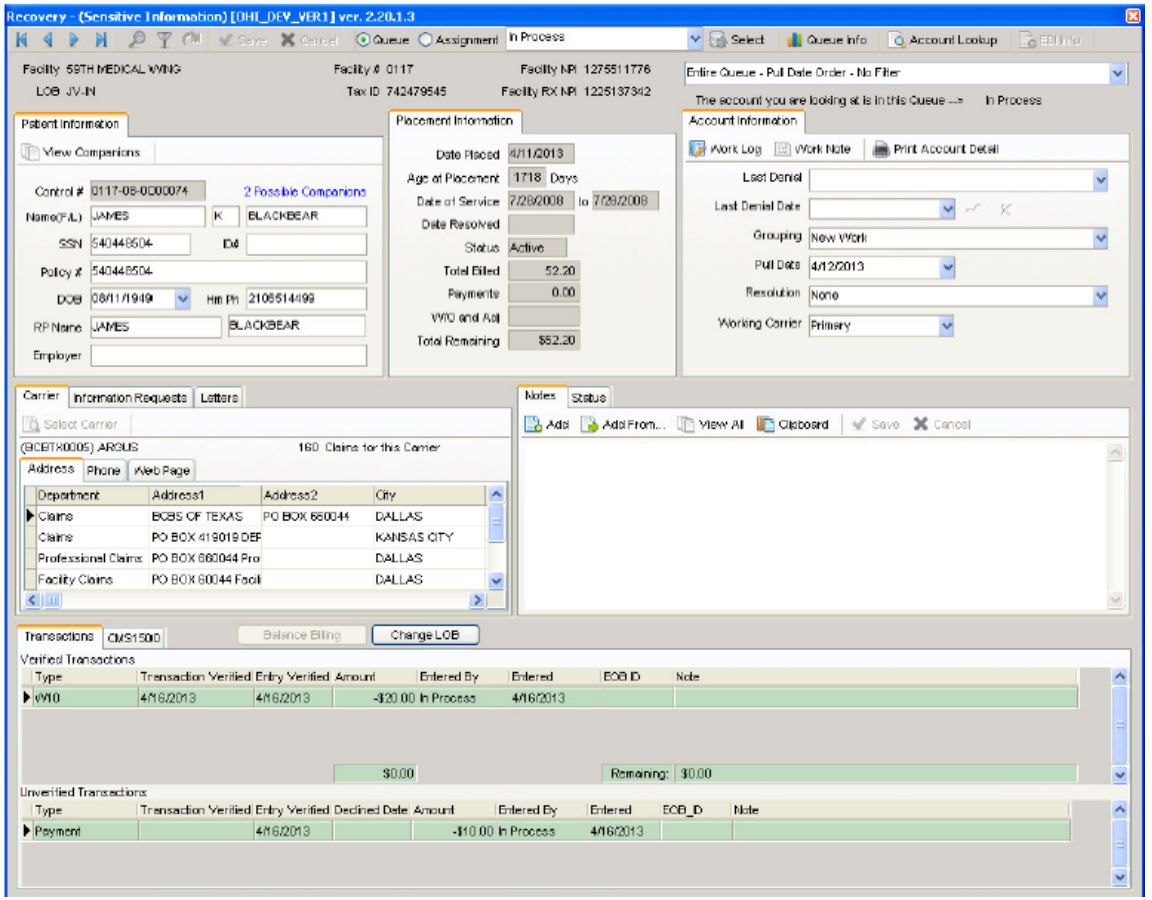
- Start tracking denials
  - Recommend capturing at least 3 months data collection
    - Electronic reports
    - Manually (can be cumbersome but can capture more detailed info)
- Group denials together by:
  - Payer
  - Type
  - Denial Reason Code
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
    - Be aware of timelines for re-filing/appealing

How to Establish a Best Practice, cont.

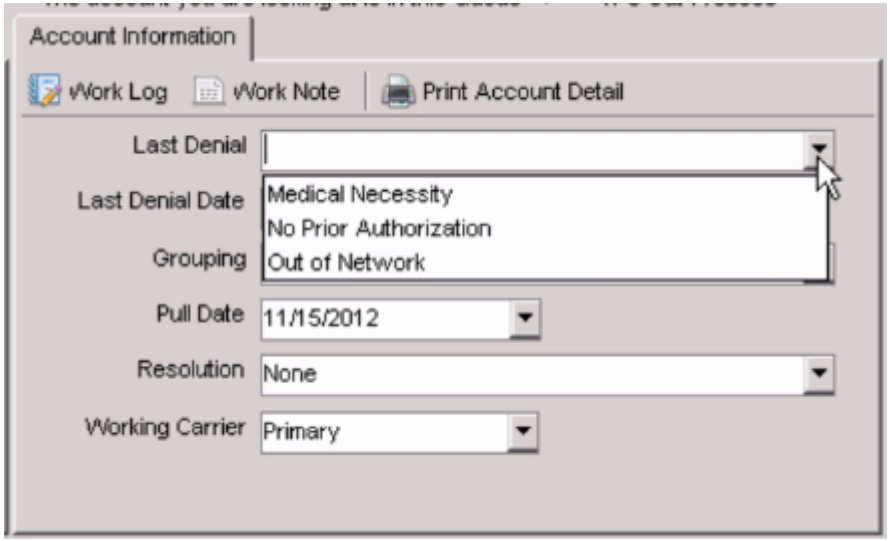
- Streamline billing responsibilities
  - Dedicate team specifically to manage denials
  - Standardize appeal templates by payer
- Show impact on revenue
  - Total amount denied by type
  - Denied amount as a percentage of revenue
  - Total write-off amount by transaction code
  - Write-off amount as a percentage of revenue
  - How much has been collected
- Establish goals
  - What is an acceptable percentage to write-off due to denials (point of reference - industry goal is 3%)
- Communicate results to leadership

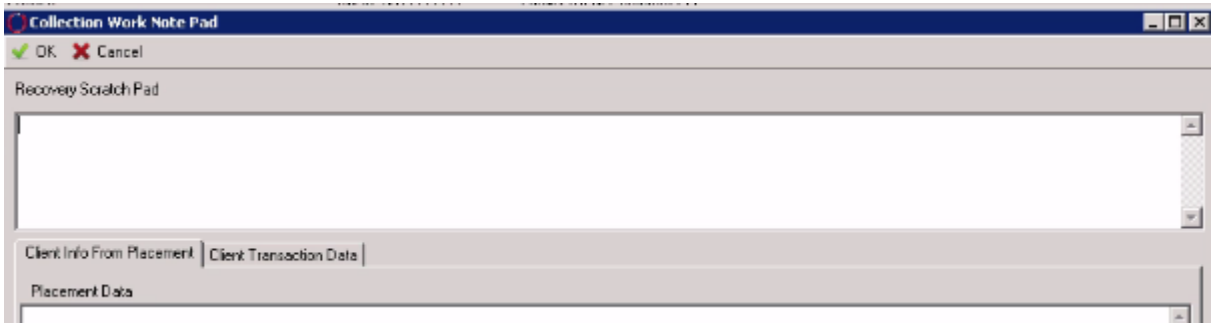
ABACUS Denials Management Features

- Accounts Management > Recovery Management
- Recovery tool used to track and reconcile accounts
- Allows users to access information, in one location, which is used in denials management
  - Account information
  - Working Notes
  - Carrier information
  - Transaction notes

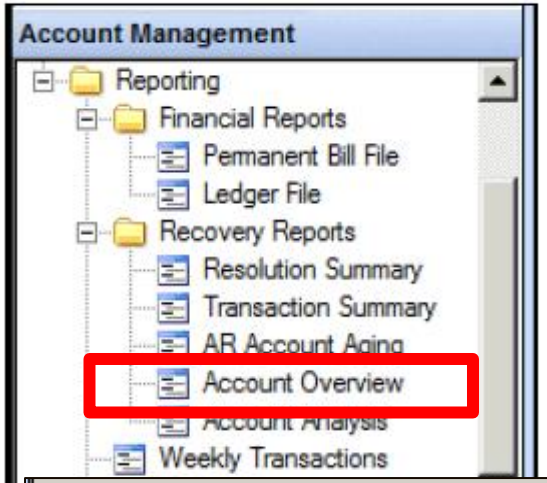


- Account Management > Recovery > Account Information tab
  - Groups denials into specific categories

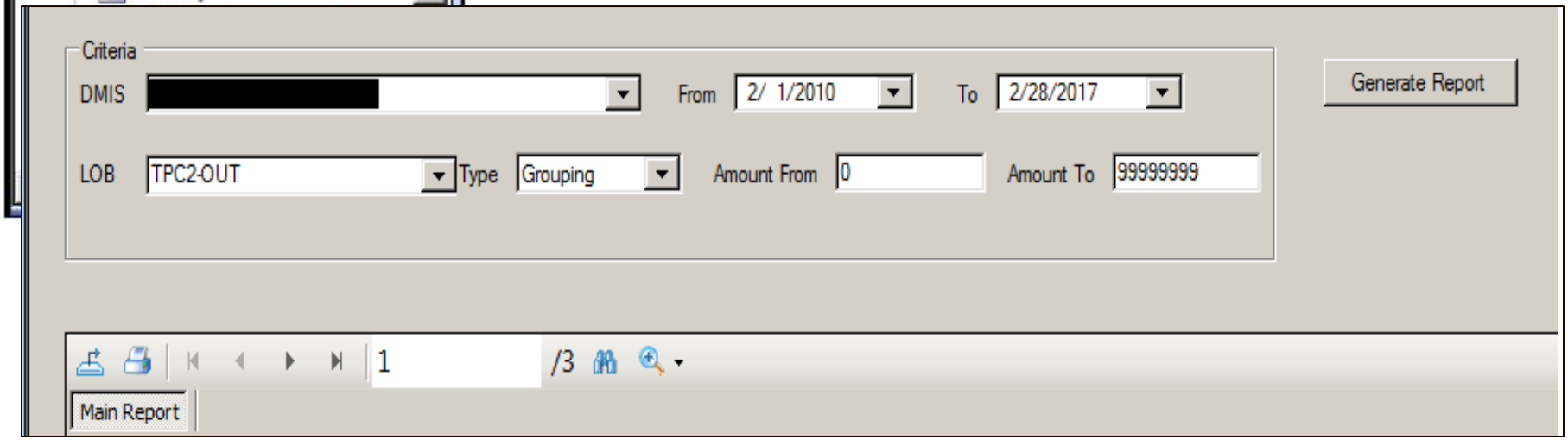




- Account Management Reports allow users to enter parameters for generating specific reports



- Account Overview
- Choose DMIS
- Date Range
- LOB



- Shows where accounts are in chosen LOB

For Official Use Only

Active Account Overview

[redacted]

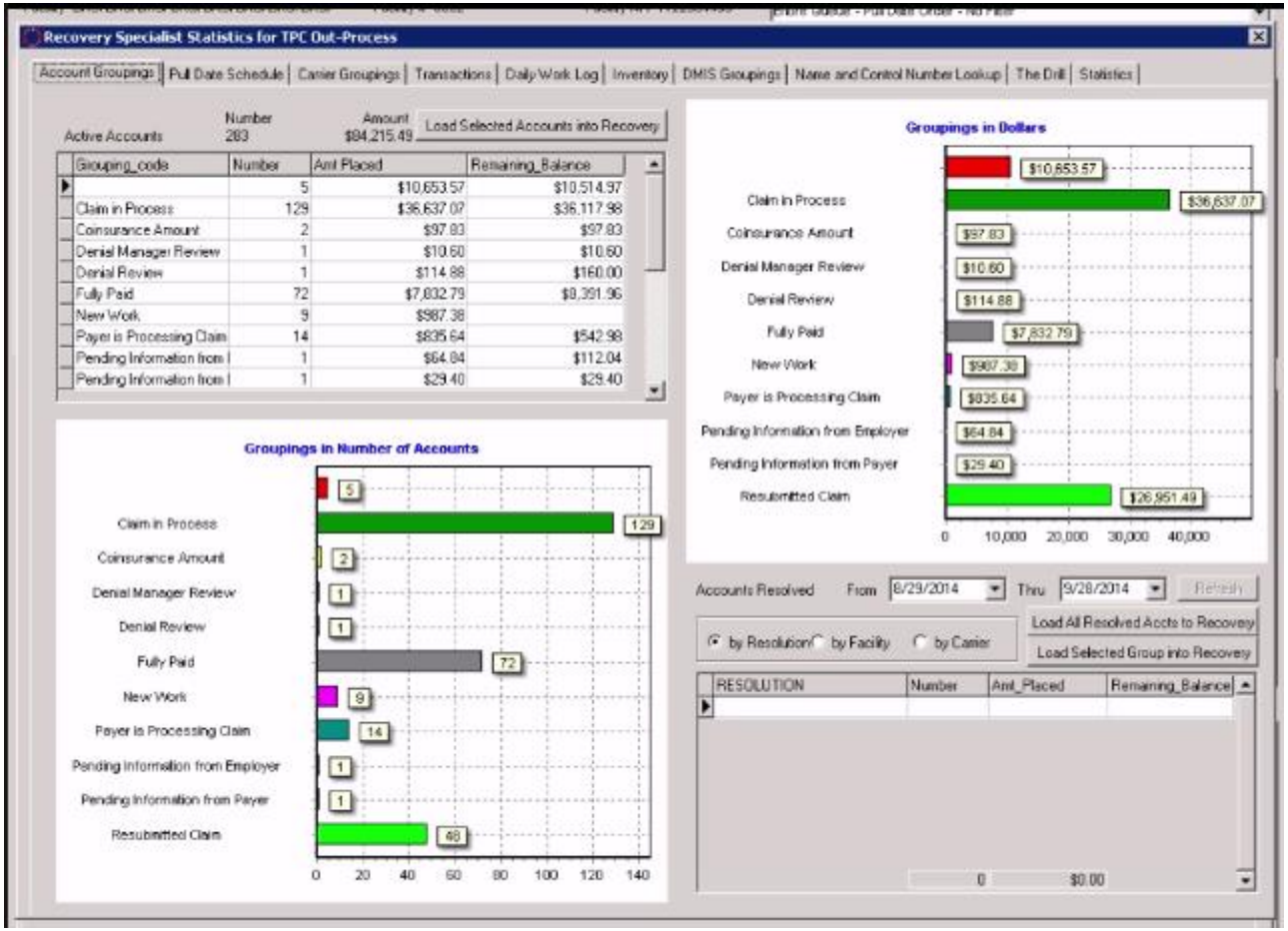
TPC2-OUT
2/1/2010thru 2/28/2017
0thru 99999999
Report Type: Grouping

[redacted]

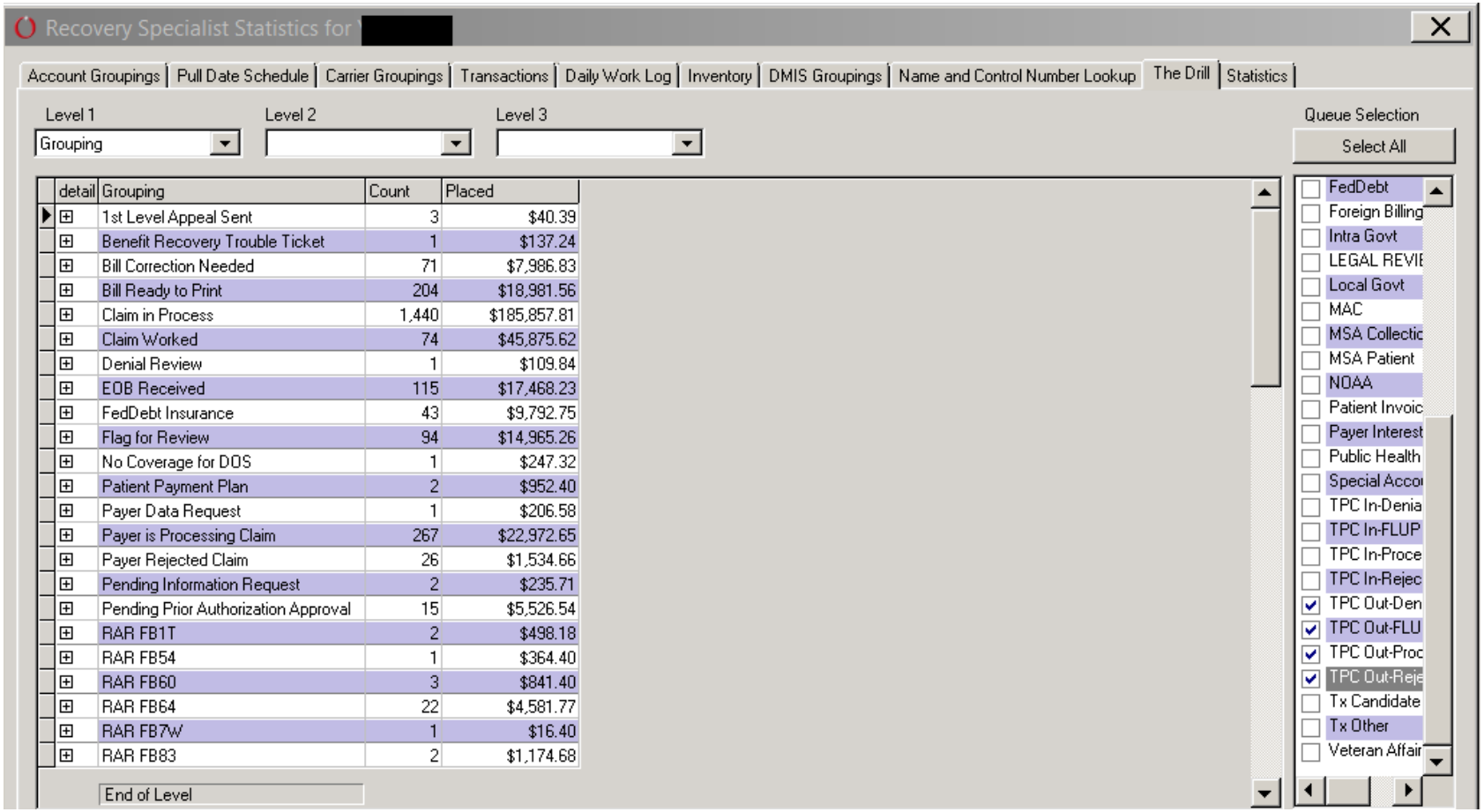
Grouping	Accounts	Billed	Payments	Write-offs & Adjustments	Remaining Bal
1st Level Appeal Sent	3	40.39	0.00	0.00	40.39
Benefit Recovery Trouble Ticket	1	137.24	0.00	0.00	137.24
Bill Correction Needed	71	7,986.83	0.00	1,124.08	6,862.75
Bill Ready to Print	204	18,981.56	0.00	0.00	18,981.56
Claim in Process	1,440	185,857.81	2,948.92	2,610.32	180,298.57
Claim Worked	74	45,875.62	4,315.22	26,977.64	14,582.76
Denial Review	1	109.84	0.00	0.00	109.84
EOB Received	115	17,468.23	269.86	460.79	16,737.58
FedDebt Insurance	45	10,148.95	204.64	358.32	9,585.99
Flag for Review	98	15,027.66	534.59	802.04	13,691.03
No Coverage for DOS	1	247.32	0.00	0.00	247.32
Patient Payment Plan	2	952.40	0.00	162.50	789.90
Payer Data Request	1	206.58	0.00	0.00	206.58
Payer is Processing Claim	267	22,972.65	601.28	226.39	22,144.98
Payer Rejected Claim	26	1,534.66	0.00	0.00	1,534.66

Tips for Tracking Denials, cont.

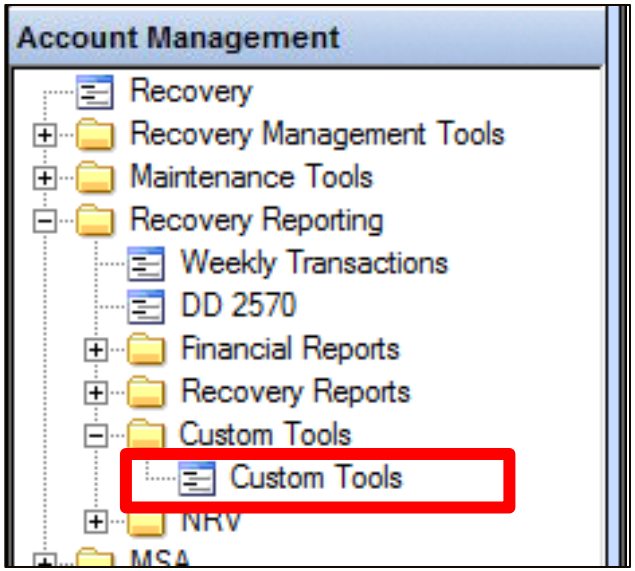
- "Queue info" allows user to access more detailed information



- "The Drill" tab allows users to search for accounts in each group



- Custom Tools has custom reports to assist and can be created upon the request and feedback from users; look for favorite ones



- Accounts in a Negative Balance
- Un-Verified Transaction Report (Accounts that need Double-Verification to close out)
- AR Clean Up Aging Report

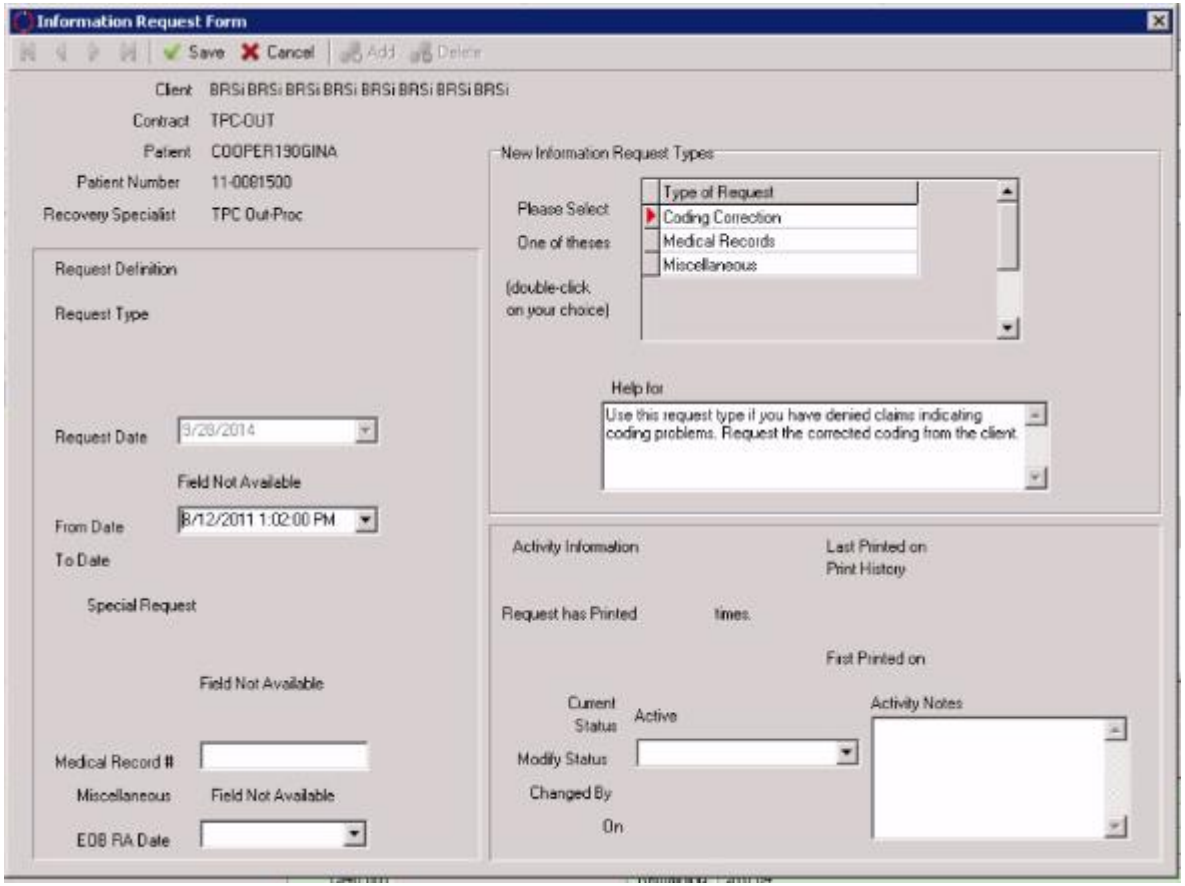
Quiz Question #3

- Why should claim denials be tracked?
  - A) To identify breakdowns in established processes.
  - B) To make appeal efforts easier.
  - C) To establish processes for preventing future denials.
  - D) All of the above

Communication Between Billers and MTF Staff

- Coders
  - Accurate coding is necessary for receiving payment
- Patient Administration Directorate (PAD)
  - Registration
  - Other Health Insurance (OHI) collection
- Clinical staff
  - Complete and accurate medical record documentation
  - Timely closing of encounters to avoid coding backlogs
- **Standardize processes in all areas to avoid inconsistencies and train frequently**

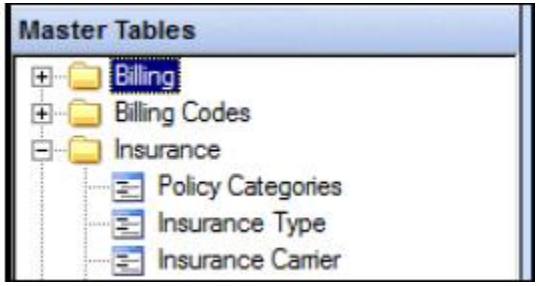
- ABACUS feature used to request information internally
  - E.g., Coding correction or medical records
  - Account Management > Recovery > Information Request tab



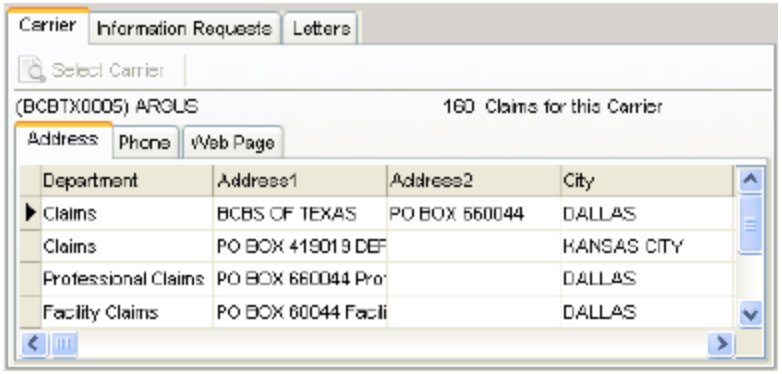
- Effective and continual communication with payers is essential
  - Develop standards for what information is required
  - Read the EOB carefully
  - Understand payer specific guidelines
  - Call the payer if a denial reason needs clarification
  - Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences
  - Develop process for receiving policy updates
  - Establish procedures for documenting communications

- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long you have to resubmit the claim?
  - Does the payer needs any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a claim when it is re-sent to indicate that it is a corrected claim?
  - Where does the information need to be sent?
  - Is there a reference number for this phone call?
  - If payer representative is not helpful, ask to speak with a supervisor

- Master Tables > Insurance > Insurance Carrier

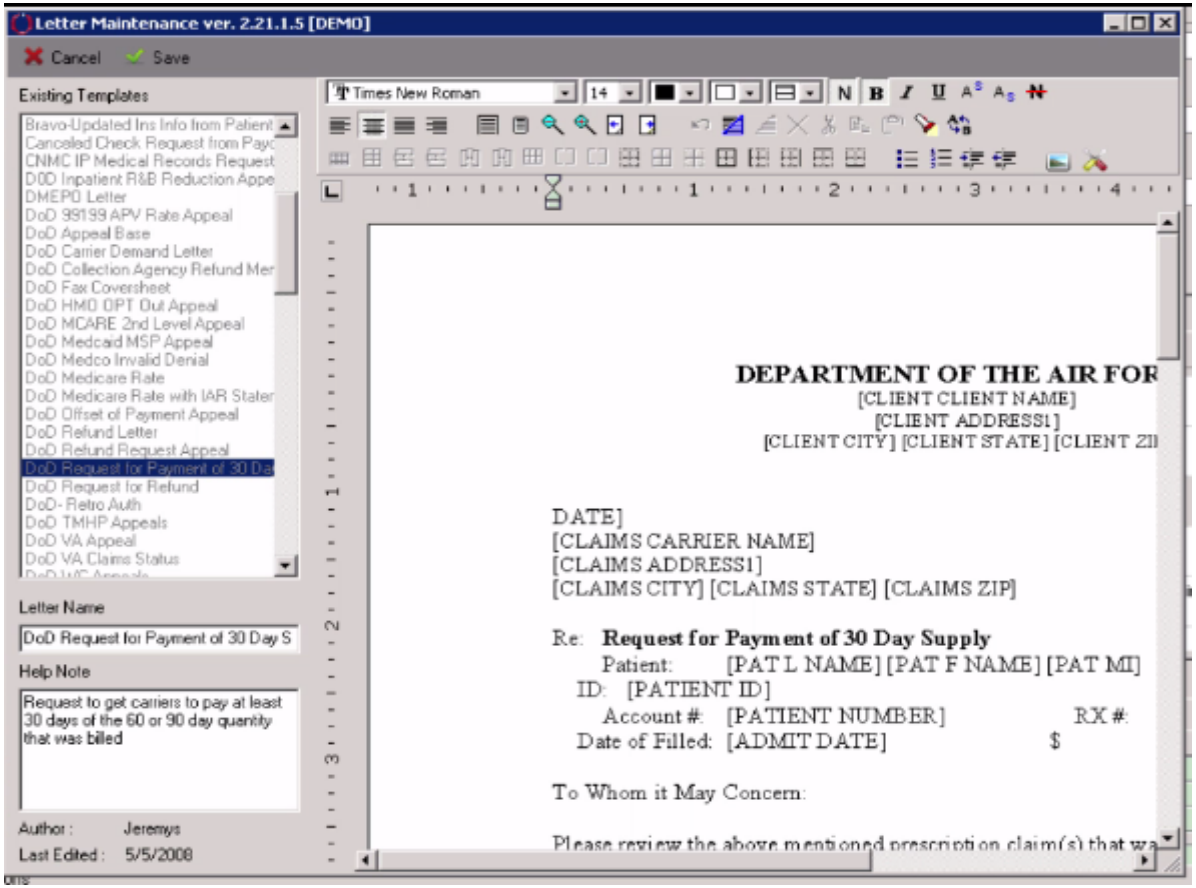


- Account Management > Recovery > Carrier Tab



- Denied claims should be pursued aggressively
  - Denied claims should be prioritized based on date of service and dollar amount; e.g., older dates of service still within timely filing limits, high dollar amounts, $5K+ (Veterans Affairs threshold)
  - Aggressive does not mean calling every day
  - Scrutinize all denied claims for incorrect information
  - Disputed claims should be communicated to the payer in writing
  - Aggressively appealing denials has been shown to reduce denial rates

- Allows users to generate letters for specific accounts
  - E.g., coversheet, appeals, patient info request, etc.
  - Account Management > Recovery > Letters Tab > Letter Editor



- Insurance companies frequently do not pay what they approve
  - They have no incentive to ensure that everything is paid appropriately
  - Track payments for approvals or overturns
    - When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial
  - Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute
- What About Upheld Denials?
  - Request the payer send supporting documentation
  - For incorrect payments, request a copy of the fee schedule
    - A list of CPT codes and dollar amounts a payer will allow for a particular medical service

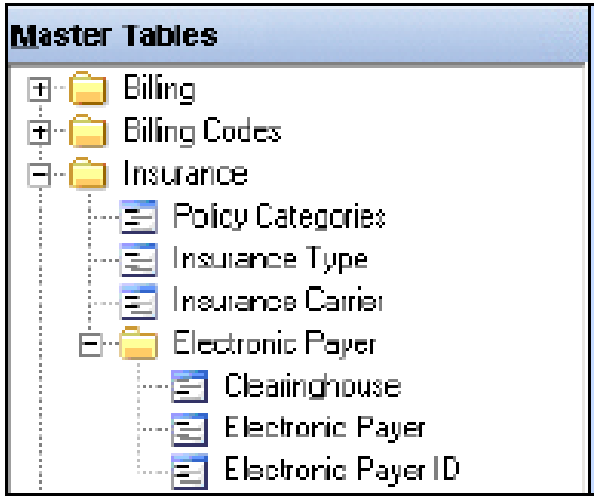
Quiz Question #4

- What should you NOT do when appealing a claim?
  - A) Track and log payer approved appeals in the event there is a dispute.
  - B) Call the payer EVERY day asking for a status update on your appeal.
  - C) Dispute claims in writing.
  - D) Prioritize denied claims based on date and dollar amount.

- If electronic institutional and professional (837I/837P) claims are sent:
  - Identify the correct payer ID for electronic transactions
  - Consult 837I/837P EDI companion guide found on payer website
  - Use the DHA UBO User Guide and online "Data and Billing in Sync" training modules to identify information that is required for 837I/837P transactions
    - Available at http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance and http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses
    - Be familiar with claim adjustment reason codes (CARC) available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Tips For Submitting 837I/837P Claims, cont.

- Master Tables > Insurance > Electronic Payer >



Summary

- Be sure to understand the denial codes on the EOB
- Focus on effective communication with payers
- Develop a strategic plan for managing individual claim denials
- Develop a method for tracking claim denials and appeals
- Make sure claims are “clean” before they are sent
- Aggressively pursue appeals
- Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance
- Submit DHA UBO helpdesk ticket, UBO.Helpdesk@altarum.org

Questions?

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  - View the entire broadcast
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